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EDITORIAL

BUTTONS.

When we were younger, rosebuds, gardenias, centaureas, small nosegays, and even "bachelor's buttons" were not uncommonly seen adorning the little eyelet or buttonhole in the left lapel of a gentleman's coat. Nowadays this is rare, except in the case of some old-fashioned fellow, who has forgotten the passing of the years.

Instead there is a multitude of buttons in evidence, and of such variety as to make it impossible to know the meaning of most of them.

The American starts young in his hunger for decorations—de-

prived, as he has been, of the various orders which, still abroad, have survived a decadent royalty.

The school-boy desires some gilded club-badge, later substituted by a fraternity emblem at college, and later increases his tokens by membership or degree insignia as he adds to his memberships in secret and benevolent organizations.

Moreover, guilds and societies of trades and professions multiply the buttons or badges as time goes on, until it would appear that special portfolios should be popular for the mere carrying of the lot.

Now comes the aftermath of the war, with the ardor of recent comradeship and the desire to perpetuate all sorts of associations. The company, army, navy, group, division or what, serves as the excuse for a new button.

The medical man who served in the war, at home or abroad, has not escaped. Already he is solicited to join the American Legion, the Medical Veterans of the World-War, the Society of Military Officers, and probably others are on the way.

The sartorial experts must soon take cognizance of the American habit and provide a proper place for display, in the future male's garments in order that a proper array may be made of the accumulated insignia; otherwise it is hardly worth while to join such bodies, unless the buttons and badges can be worn so as to attract the notice of others who may have also forgotten them.

There can be no objection to reasonable organization of groups of men when there is definite purpose in such organization, but, when a multiplication of organizations occurs, where like purposes obtain in each, there should be some crystallization for better effort and, above all, there should be some reform in the button habit.

ORIGINAL ARTICLES

(No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. Reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.)

INTRA-PERITONEAL RUPTURE OF THE BLADDER DURING PUERPERIUM.*

By W. KOHLMANN, M. D., New Orleans.

Rupture of the bladder is considered a very infrequent accident. Ziegner, in a monograph, mentions that in one of the hospitals in Berlin three cases came under observation out of 11,000 patients; in Bartholomew Hospital in London, two out of 17,000 patients, and in the Clinic in Halle, six out of 9,500 patients. Large statistics show, however, that rupture of the bladder is more frequent than was generally believed, and is found more often than ruptures of the liver, kidneys and spleen.

Rupture of the bladder may involve one or all three coats of the bladder. It may be *intraperitoneal,* involving the peritoneal covering; *extraperitoneal,* involving the portion of the bladder *not* covered by peritoneum; or *subperitoneal,* when the mucous and muscular coats are ruptured, leaving the peritoneal covering intact, the urine diffusing under the peritoneal covering. The last variety is very uncommon.

This affection is found more often in men than in women, 90 per cent of the cases reported having occurred in adult males. Few cases only are reported in women, and these were mostly caused by complication with retroflexion of the pregnant uterus. In one case reported by Porter to the Obstetrical Society of London rupture of the bladder occurred during birth. The patient had not urinated for a long time, and suddenly felt something had given way in the abdomen. Soon distention set in and pulse got very fast. Forceps had to be used to deliver the child. Delivery was followed by laparotomy. Tear of the bladder one and one-half inches long was found and sutured. Rupture was considered due to extreme distention of the bladder.

The two cases, the details of which I am going to report, occurred

*Read at the Fortieth Annual Meeting, Louisiana State Medical Society, Shreveport, La., April 8, 9, 10, 1919.

in women who had recently been delivered. In one case, the patient went through an absolutely normal delivery, while the other had to be subjected to a Cesarean operation.

Case 1. Mrs. T. J. F., age 28 years, admitted to Touro Infirmary September 8, 1918; discharged September 30, 1918. Father died of paralysis, aged 63; mother, aged 64, living and well; three sisters and four brothers living and well. One brother killed accidentally. Patient has been married four years. One child, three years of age; no miscarriages. Regular menstruation every twenty-eight days, duration four days; no pain. Patient does not remember any previous illnesses. In the delivery of the first child, three years ago, forceps were used. Second delivery was normal. Patient well nourished and developed.

Was admitted to Touro at 10:30 a. m., Sunday, September 8, 1918. Membranes had ruptured at 10 p. m. the night previous, and the pains began two hours afterward. At 11:30 a. m. she gave birth to a 7-pound, 3-ounce female child; normal delivery. Pituitrin, 1 c. c., and ergot, 1 dram, every four hours for twenty-four hours was given; rilox, 1 ounce, was given on the morning of the 9th.

The patient slept well the night of the 8th, the first night after delivery; did not complain on the 9th, and had a comfortable night. During this time there is a record, in the summary of the second day after delivery, of the patient having voided, it being noted on the first day that she had not voided either during the day or during that first night. Urine recorded as follows: September 8, day 0, night 0; September 9, day 1, night 1 (at 2 a. m.).

September 10 and 11 chart records urine passed, but no records of the amount or the time. On the 12th there is no notation as to urinary function.

The chart records the first complaint of pain the afternoon of the 10th; pain chiefly in the back. Patient complained of pain in early part of night, but slept well after midnight until 5 a. m.

On the 11th the patient complained still of pain in back and abdomen, and slept well that night.

On the 12th the patient complained of severe pain in abdomen, was given a purgative enema with good results, but no relief as to pain.

During examination of the abdomen, which was rather distended and painful by touch, patient felt something giving away, and suffered excruciating pain, accompanied by shock.

Patient continued suffering a great deal of pain during the afternoon, and getting worse generally, pulse increasing in rapidity—140 per minute.

At examination by myself at 6:30 p. m. patient presented the typical picture of an acute abdomen—greatly distended abdomen, general pain over abdomen. Temperature normal; pulse 140; respiration 38. Vaginal examination was negative.

Considering the previous history, probable diagnosis was rupture of ovarian cyst, and immediate operation was decided upon.

Operation, 7:45 p. m. Median incision below umbilicus. Evacuation of several gallons of light brownish liquid, which was odorless. Ovaries were normal. Large opening in posterior wall of bladder, three to four inches in length, was found, and closed by continued through-and-through suture, which was covered by interrupted Lembert suture. Abdomen was

drained by rubber dam and iodoform gauze (Mikulicz). Suture of abdominal wound in usual way. Pezzer catheter was introduced in bladder and removed at the end of the seventh day.

The patient made an easy recovery and left the hospital September 30, 1918.

Case No. 2. (Case of Dr. J. W. Newman, which he has kindly permitted me to use in my report.) Mrs. W. G., white, aged 38 years, admitted to Charity Hospital July 27, 1918. Measurements slightly below normal; history of convulsions given to interne on ambulance. No other history available. Patient deaf and dumb. Urine examination showed 26 per cent albumin.

On admission, morphia, one-quarter grain, was given in amphitheater. One hour thereafter another convulsion. Taking pelvic measurements into consideration, Cesarean section was performed, and a living child delivered. During first three to four days there was no nausea or distention. Pulse and respiration good.

July 28.—Patient complained of severe pain in abdomen. Slight distention. Pain and distention increased. Temperature 103°.

July 29.—Good night. Severe pain in morning. Urine voided with stool.

July 30.—Great deal of pain and distention.

July 31.—Same condition.

August 1.—Distention. Dressing changed. Profuse serous vaginal discharge of very offensive odor. Distention somewhat relieved by enema and pituitrin.

August 2.—Distention somewhat relieved.

August 3.—Free drainage of pus from abdominal wound. Incision was opened and drainage tube was introduced into abdominal cavity, followed by discharge of several quarts of straw-colored liquid without characteristic odor.

Patient became gradually weaker, and died the night of August 6.

Autopsy: Introduction of hand into abdomen allowed escape of straw-colored, weakly ammonia-scented fluid (about one gallon). Extensive adhesions of omentum to anterior surface of uterus and posterior surface of bladder; careful removal of omentum revealed rupture of bladder about an inch and a half in length on posterior surface.

Atony of the bladder, ulceration of the vesical walls and cystitis are predisposing causes of this occurrence. Several cases of rupture are reported where the bladder wall was found hypertrophied. In about half of the reported cases the bladder wall was found normal. A very important predisposing cause is drunkenness, especially if complicated with some form of external violence applied over the region of the bladder. Cabot draws special attention to the importance of intoxication. In this state there is a diminished reflex activity, and a man will neglect to empty the bladder, which leads to overdistention of the organ.

Traumatism, however slight, is generally the exciting cause. The

trauma may be so slight that in many cases a spontaneous rupture could be considered possible. Straining, not necessarily violent, during defecation, micturition and parturition has been known to produce rupture. Rupture has occurred in overdistention from injection of fluid preparatory to suprapubic operation and during anesthesia, when the bladder was already distended, no doubt due to increased intra-abdominal pressure. Rupture by contrecoup has occurred by the patient falling from a height and striking on feet or buttocks, even with a comparatively empty bladder.

The most frequent location of the rupture is the upper and posterior portion of the bladder, and this may be accounted for by the fact that the distended bladder lies in contact with the promontory of the sacrum. Force applied in front presses the distended organ against this bony point. Furthermore, the bladder wall is thinnest on this location, and only covered by peritoneum and the intestines. Most of the ruptures anteriorly are complicated with fracture of the pelvic bones.

The tear is usually linear, with ragged and everted edges. Even if there is usually only one wound in the bladder there are cases reported with several rents found. In many of the reported cases, as in the cases under our observation, the bleeding from the bladder wall was practically *nil*, showing that the bladder wall on the upper and posterior portion is thin and poorly nourished, predisposing this part of the organ to give way.

If the rupture is intraperitoneal and urine flows in the free abdominal cavity, then the fate of the patient depends, first of all, on whether the urine is sterile. In case cystitis is present, or careless catheterization infects the abdomen, prognosis is bad. Therefore it is justifiable, in case of suspicion of bladder rupture, to catheterize only once, and only when everything is ready for immediate laparotomy. The danger of infection is more important than the danger of urine intoxication. But, after all, the intoxication is not without importance, though in former years uremia, due to absorption after rupture, was exaggerated. At the present time such cases are not frequently observed, as the majority of them come under observation much earlier.

Oehlecker (Eppendorf Hospital, Hamburg) reports two cases, where operation was done eight days after rupture, and only in such delayed cases can we see the effects and importance of intoxi-

cation, when the rupture has taken place many days previous and the infection of the abdomen does not figure in the condition of the patient. He found a large quantity of fluid, the intestines *not* distended, the peritoneum congested, but absence of exudates which are usually found in peritonitis.

But as the abdomen, filled with urine, is greatly susceptible to the development of bacteria, an early diagnosis is absolutely essential. In the majority of cases the diagnosis ought to be possible.

After an injury (frequent sensation of something given way) the patient shows symptoms of shock of varying intensity and complains of sudden or severe pain in hypogastrium, frequent and painful micturition, inability to void, or possibly a few drops only, mixed with blood. (Blood in urine is not of diagnostic value, as it is also present in contusion of bladder and injury to kidneys.) Soon symptoms of peritoneal irritation develop, such as severe pain, distention of abdomen, rapid and feeble pulse. Nausea, vomiting and tenderness are usually not marked. If diagnosis should not be possible, the use of a catheter may be indicated. The catheter empties usually a small quantity of bloody urine. An important symptom is the evacuation of a large quantity of urine, which is even more important than anuria. This amount is obtained direct from the abdominal cavity (the catheter having passed through the rent of the bladder into the abdominal cavity). The normal bladder, according to Rauber, contains 735 c. c. in the male and 680 c. c in the female. Presence of free liquid in the abdomen can be very early observed, and was recognized in our first case.

In cases of more delayed observation, symptoms of general peritoneal irritation develop, presenting the symptoms of an acute surgical abdomen, which make the exploratory laparotomy absolutely necessary. If rupture of the bladder is found, it is essential to secure either the drainage of the urine or to suture the opening in the bladder. If the suture of the bladder wall, and especially the Lembert suture, is successful, and if there is only clear serous liquid in the cavity, the abdomen may be closed without drainage.

To use gauze as drainage in a suture of the serous covering is not without danger, as such a drain may be dangerous to the suture, instead of making it more secure. The gauze gets very densely adherent to the serous membrane, and it is possible to tear the

serous wound in removing the gauze drain. It is preferable to use a rubber dam in case drainage should be indicated.

The earlier the cases are reported the better are the chances of recovery. The mortality increases in proportion to the time which passes between the injury and the surgical interference. Of sixteen patients reported by Wiedeman, six were operated in the first twenty-four hours; only one died—a mortality of 16 per cent. Zuckerkandel reports that of thirteen cases operated in the first twelve hours, eight recovered and of twenty-one patients operated later only six recovered.

Improvement in surgical asepsis and technic makes the suggestion possible that at the present time every patient suffering from this accident ought to recover, if there is no cystitis existing and if the injury is recognized early enough to prevent secondary infection from setting in.

Discussion of Dr. Kohlmann's Paper.

Dr. A. Nelken: The subject of rupture of the bladder is one of interest, and yet it is of comparatively infrequent occurrence. In my experience I have only seen one case, a patient that Dr. Gessner will probably recall, a case of advanced tuberculosis of the bladder in which we gave a general anesthetic because of the impossibility of doing anything without an anesthetic. The patient vomited considerably during the examination, and in spite of the anesthetic we were unable to make a satisfactory cystoscopic examination. The rupture was not recognized at the time it occurred. I believe this patient died.

Dr. Kohlmann touched on one point that I think ought to be emphasized in these cases of retention of urine, and that is that a history of voiding urine is absolutely unreliable. The patient who has retention of urine will usually come complaining of inability to hold his urine, and the nurse, if careless, is very much inclined to confuse the record and give us a false impression, and I think that is exactly what occurred in Dr. Kohlmann's case.

Rupture of the bladder, except from traumatism, is much more likely to occur in cases of acute distention of the bladder than in chronic distention. The bladder subjected to chronic distention is usually hypertrophied. In old cases of prostatic obstruction the thickness of the bladder wall is remarkable. These cases of chronic obstruction, that are due to stricture, to enlarged prostate, to inability to relax the sphincter, usually are accompanied by hypertrophy, but rupture there, except from violent traumatism, is extremely rare. It is remarkable the amount of fluid the bladder will contain under these circumstances. I have myself drawn from such a bladder seventy ounces of urine. When we consider that the normal capacity of the bladder is about ten or twelve ounces, you can appreciate the degree of distention that occurs in some of these cases. I have had a little fellow of twelve years come to my office—this was about a week ago. He is twelve years old and under-

size, and the first thing that alarmed his parents was the fact that his abdomen was so large. He voided fourteen ounces, and with a catheter I obtained twenty-six ounces—forty ounces in all—and this was giving him absolutely no discomfort. Rupture of the bladder is much more likely to occur with acute distention. The bladder wall is thinned out, and very frequently the slightest external violence may produce rupture, such as occurred in the first case Dr. Kohlmann referred to.

Dr. E. M. Ellis, Crowley: The late lamented, but illustrious, John matic rupture in the male. He had an injury, which was apparently, by external examination, along the roof of the bladder. A catheter was introduced and a little blood was noted. Injury was suspected, so the catheter was retained and the fluid flowed so freely that we opened the abdomen and a large rent was noticed, so we closed it up, as Dr. Kohlmann mentions, with drainage.

The point he mentions about noticing the patient does pass urine should be very cautiously noted and records made, and, if not, the patient should be carefully examined to see if there is a tumor. I remember a negro woman who said she could not hold her urine at all. She was found to have quite a tumor, and was immediately relieved by the removal of the tumor. Another woman had not passed urine for thirty hours, and I believe she would have had a rupture of the bladder if the catheter had not been passed at that time.

Dr. W. Kohlmann (closing): It is not alone the rupture of the bladder we have to fear, but if the bladder is overdistended it no doubt sometimes causes infection of urine. I believe that a great many cases of cystitis that develop after women are delivered are due to the fact that they have had infection of urine. But my impression is that the bladder is the most vulnerable organ. In the operations in the vaginal region we often find the bladder does not empty well. It is not right to blame the nurse. I think we have to blame ourselves and the interns who do the work for us in the hospitals. We can easily find out if the patient does not empty the bladder. Following operation I think this a frequent occurrence, and it is not right to blame others for an injury we allow to occur.

THE VALUE OF THE X-RAY DIAGNOSIS OF BONE SYPHILIS.*

By AMÉDÉE GRANGER, M. D., New Orleans.

Two cases examined recently demonstrated so forcibly the importance of the X-ray diagnosis of bone syphilis that I decided to select this important subject for my short contribution to your program. I will state briefly the practical lessons I have learned from the study of these and other equally interesting cases of bone and joint syphilis which I have examined with the X-rays.

As you well know, and as will be shown by the brief histories of

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the five cases selected for this report, bone and joint syphilis can exist in patients giving a negative personal and family history of syphilis, and not as infrequently as most of us would suppose in patients giving a negative Wassermann, and even occasionally in patients who are not benefited by the usual doses of mercury and iodides, but who respond to these drugs when the dosage is pushed to the point of saturation, with the production of decided physiological effects.

Clinically, cases of bone syphilis resemble Paget's disease or chronic osteomyelitis, or, when the gumma formation in the soft parts is extensive, osteo-sarcoma. The latter is, of course, the more serious clinical error, and by no means as infrequently made as you would suppose.

Clinically, cases of joint syphilis resemble chronic arthritis, or chronic rheumatoid arthritis, or tubercular arthritis. The latter is the most serious, and not at all a very uncommon mistake in diagnosis.

The following cases were examined by me, either in my hospital clinic or in my private office. They gave histories and presented clinical pictures which justified diagnoses other than syphilis, and in every instance except one the X-ray examination was made to ascertain the extent of the bone or joint involvement and destruction produced by the disease diagnosed, so as to enable a correct prognosis to be made. The syphilitic nature of the affection was not suspected, and it was diagnosed exclusively from the careful study and interpretation of the skiagraphs made, and in spite of all evidence to the contrary, such as negative Wassermann and failure of the usual dosage of mercury and iodides to ameliorate or improve the condition.

I wish to disavow even the slightest intention to find fault with the clinical diagnosis made in these cases, as I am convinced that none other could have been made, and the gentlemen who made them are all eminent members of our profession. But I hope to convince you of the possibilities of errors in diagnosis, even after the most careful search into the histories and the most painstaking physical examination of this class of cases, and also that you possess in a correctly made and interpreted X-ray negative the quickest and most reliable means for the accurate diagnosis of chronic and obscure conditions of bones and joints.

Case I. Syphilis of the Inferior Maxilla. White male, age 55. Examination showed a very hard swelling of the inferior maxilla, with a small sinus discharging bloody fluid. He complained of a more or less constant dull ache, with occasional lancinating pains in the affected jaw. A diagnosis of osteo-sarcoma was made and resection of the inferior maxilla was advised. This was in 1906. At that time the use of the X-rays at our Charity Hospital in New Orleans was limited almost exclusively to the study of fractures, dislocations and foreign bodies. Cases of bone and joint affections were seldom referred to the X-ray department, and there were not over two or three skiagraphs of osteo-sarcoma in the negative file of the department, which had but a short time before this been installed. On hearing of this case I requested the privilege of making a skiagraph of the patient, with the object of adding one more case of osteo-sarcoma to the young collection for future study and comparison. To my surprise, the skiagraph made showed positively that the condition was not sarcoma, but syphilis of the inferior maxilla, with a large gumma of the surrounding soft parts. At first the correctness of my interpretation of the plate was doubted, because the patient gave a negative history of syphilis, and the clinical picture was quite typical. However, it was decided to defer the operation, and, as this was before the discovery of the Wassermann reaction and the salvarsan treatment, to put the patient on large doses of mercury and iodides for two weeks. He improved almost immediately, the mass becoming softer, then smaller, and finally disappearing altogether.

Case II. Syphilis of the Upper End of the Femur. White male, age 35. For several months had been having severe pains in the hip. The movements of the affected hip were so painful that he was confined to his bed most of the time, and could only get about on crutches and with considerable difficulty and discomfort. Even passive movements were very painful. Medication had given no relief and the loss of weight was very marked. Tuberculosis of the hip was diagnosed and the patient was referred to the X-ray department for examination and report on the extent of involvement and destruction of the femur and the acetabulum by the tubercular process. After a careful study of the skiagraphs the diagnosis of syphilis of the femur was made and a Wassermann suggested. This was made, with negative findings. Later a Wassermann was made of the spinal fluid, with negative results. In spite of the negative Wassermann I was still so certain that the bone condition was syphilitic, and not tubercular or some other disease, that I advised mercury and iodides. Neither was my opinion changed when, after two weeks' administration of the protoiodide, the intern reported no change in the condition of the patient, and I advised him to give mercury by inunction and increasingly large doses of iodides to the point of saturation. Two days after the patient showed the marked physiological effects of these drugs the pains began to leave him, and within another ten days he was entirely free from them and could make use of the affected hip.

Case III. Syphilis of the Skull. Colored male, age 23. On palpation a very hard mass the size of a large orange could be felt on top and back of the head. This mass was first noticed about eight months before the patient's admission to the hospital. Although not painful to the touch, he complained of a more or less constant pain in it. At times this pain became very severe and radiated through the whole head. A clinical

diagnosis of osteo-sarcoma was made and an X-ray examination requested. The X-ray diagnosis was syphilis of the skull, with a large gumma of the scalp. A Wassermann was made, and the reaction was positive. Cure followed appropriate medication.

Case IV. Syphilis of Ulna. White female, age 30. For eighteen months pain and loss of function in the elbow joint, and during the latter six months a small discharging sinus, which had persisted after an abscess had been opened and drained. The patient was living in Denver, Colo., where the condition was diagnosed as a tubercular arthritis, and she received various treatments, including applications of the high frequency currents and the X-rays, without any benefit. The physician whom she consulted on her arrival in New Orleans immediately referred her to me for an X-ray examination to determine the extent of bone and joint involvement and destruction by the tubercular process, in order to enable him to advise appropriate treatment and to make a prognosis. The skiagraphs showed clearly and unmistakably syphilis of the upper end of the ulna, and no joint involvement or destruction. The patient got well rapidly on appropriate medication.

Case V. Syphilitic Arthritis of the Third Cervical Articulation. White male, age 35. Complained of pain and stiffness in neck and head for eighteen months, greatly increasing in intensity during the last four months. Treatment, including massage and electricity and several months of osteopathy, gave only partial relief of a very temporary character. A diagnosis of chronic rheumatoid arthritis of the cervical spine was finally made and he was referred for X-ray confirmation. The skiagraphs, instead, showed a typical syphilitic arthritis of the third cervical articulation. Two Wassermann examinations were negative, but the patient improved rapidly and was cured by appropriate intensive medication.

Discussion of Dr. Granger's Paper.

Dr. S. C. Barrow, Shreveport: A paper such as Dr. Granger has given us can really only be appreciated by a man doing X-ray work. I want to congratulate Dr. Granger not only on having made these clear and ultimately proven accurate diagnoses, but also on his usual characteristic painstaking care and attention to the details of his work, an attribute which we formerly were prone to credit to the Germans, but which we now know is particularly characteristic of our confrères, the French.

Dr. Granger is Louisiana's pioneer in X-ray work and I respect his opinions always on anything pertaining to X-ray, and when he draws these conclusions I am sure they are right, and in line with what I have known of him for a long time.

In this bone work, the original work in X-ray, we should try to hold in mind the thought always that the X-ray plate is an illustration of relative tissue density, and when we hold in mind that syphilis usually gives a sclerosis or increased density, that tuberculosis usually gives a decreased density, and that the malignancies have their characteristics running between these two, with care and attention given to the study of the plate, as Dr. Granger does, we can surely find the X-ray of the greatest help in clearing up these diagnostic conditions.

Dr. C. L. Chassaignac, New Orleans: I had not intended to take the floor, as my experience in X-ray work is entirely secondary and furnished by the man who does the actual work, so I will simply say, in confirma-

tion of what has been said, that the X-ray plates have enabled us to make great progress in making early diagnosis of these conditions, and we have improved to this extent, that, while formerly, even with the aid of the Wassermann reaction, we were somewhat in doubt as to the type of a tumor or a bone involvement, nowadays the X-ray plate assists to a great extent, and we do not have to wait for the so-called therapeutic tests as before. That is, in cases of this kind, we formerly gave the patient the benefit of the doubt and tried specific treatment before consenting to an operation being performed, especially if such proved serious. At times it is not an easy question to determine this in supposed bone syphilis. To-day, when we have proved that so many different causes can bring about the same results, we are very glad indeed to be able to fall back on such a distinct aid to early diagnosis.

I will state a case that came under my observation not long ago, simply to illustrate the difficulties under which we labor, notwithstanding the improvements that we have made in our knowledge regarding the cause of these troubles. This was a man of about middle age who presented himself with chronic arthritis, so-called, of both knee joints. The question, of course, was to determine the cause of the arthritis. This man was found to have had syphilis—there was still evidence of the disease, as shown by the Wassermann test. He was found to be still suffering from a prostatic infection which we knew could also lead to arthritis, and, in addition to that, had what we used to believe was the main cause of this condition—a so-called excess of uric acid. On further investigation we found he had a decided infection, as confirmed by his dentist, of the roots of at least two teeth, so there were four possible causes for the arthritis. We treated him from these four different standpoints and he got well.

The point I want to bring out is that frequently the X-ray plate will help to decide the true condition, and in that way assist us very much in our proper understanding of the case.

Dr. G. H. Cassity, Shreveport: Dr. Barrow made the statement that only the doctor doing X-ray work could appreciate some of the things in this paper. From the standpoint of a clinician I maintain that statement is not correct. I believe the clinicians are coming to appreciate the X-ray as one of the greatest helps for them at the present time. Speaking for myself, I have come to the point that I feel if Dr. Barrow were to leave town I could not practice medicine. Not only do we use it in general surgical work, but when a patient comes to me with rheumatism and I cannot definitely locate the foci of infection I send him to Dr. Barrow and have the teeth photographed, and if you get in the habit of doing that you will be surprised how many foci you will locate in the roots of teeth that the patient does not suspect. I hold a small renal calculus in my fingers that was removed from a kidney not long ago. It is very small and was imbedded in the lower pole of the kidney. If I had not had a picture of it I never would have been able to remove it. I hunted for it for an hour, as it was. So I wish to assure the X-ray men that the clinicians appreciate their work and feel they have certainly come to stay.

Dr. Amèdée Granger (Closing): I want to thank the gentlemen for their discussion and to reiterate one point—that is that the therapeutic tests, so-called, are only of value after you have saturated your patient with mercury and the iodides.

EMPYEMA.*

By B. C. GARRETT, M. D., Shreveport, La.

The subject of empyema is one that has attracted a great deal of attention within the past eighteen months, on account of its great prevalence—the many ways in which it was treated and the kind of organism which produced the particular empyema that we have to deal with. The condition has been treated by many different methods, and I think it will continue to be until we settle definitely on the best and safest method of handling them. To one that has spent some time in the army and has seen the many ways the cases were handled it certainly looks as if the Empyema Commission sent out from Washington by the Surgeon General in August, 1918, has struck upon the keynote in handling these cases. And it is to their report and to Major Max Ballin's article in the *Jour. of the A. M. A.* that we wish to acknowledge some of the ideas that appear in this paper.

We wish to classify empyema here into three groups: (1) Those following influenza pneumonia; (2) those following streptococcic hemolytic pneumonia; (3) those following lobar pneumonia.

Empyema following influenza pneumonia occurs, as a rule, late, about three to five weeks; the exudate that occurs before this time will most probably be absorbed as the pneumonia clears up. The fluid is of a purulent nature, very thick, and hard to aspirate. In the empyema following streptococcic hemolytic pneumonia the fluid occurs early, very thin, greenish in color and evidently very toxic, because those patients are always desperately ill from the beginning. The empyema following lobar pneumonia shows a definite level by X-ray, occcurs about the fourth week, whereas empyema following influenza pneumonia has no definite level, but shows more or less the involvement of the whole lung. Autopsy bears this out. We sometimes have double empyema in influenza pneumonia, but we seldom ever have it in lobar pneumonia. We have numerous complications in influenza empyema, such as cholecystitis, peritonitis, metastasic abscesses, meningitis, and mastoiditis, but seldom, if ever, have these in empyema following lobar pneumonia.

The diagnosis of empyema is made by (1) history of the case; (2) watching the temperature, which will usually be up and down; (3) by physical findings; (4) by X-ray (I think I am correct when

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I state that some of these cases develop fluid in the chest cavity very rapidly, as shown by X-rays); (5) by aspirating needle. We rely a great deal on the X-ray and aspirating needle in these cases, as the physical signs are sometimes misleading when the pocket of pus is encysted within lung tissue.

The treatment of these conditions, as we see it, is along the lines as laid down by the commission spoken of above: (1) Not to operate as long as pneumonia is present; (2) to aspirate if quantity of serous exudation is such as to interfere mechanically with respiration; (3) operate only after pneumonia has subsided and when fluid has become purulent, by intercostal drainage, or, better, by rib resection. These rules reduced the death rate at Camp Lee from 50 to 4 per cent. We heartily agree on this late operation, and it has proven most satisfactory, both while in the army and with the cases that we have had since my return. Early operations are more dangerous, because pneumonia is present; shock greater, pus more liable to become pocketed after operation, and, as pointed out by some one, that the blood stream is more liable to become infected.

Continuous drainage by puncture is in favor of the early operation of these cases, but, as they seem to carry a great deal of this fluid for a long time with impunity, rib resection under local anesthesia, except in cases of children, when a whiff of chloroform carefully administered is preferable. The resection should be done as nearly over the pus cavity as possible, where drainage will be best when the patient is either lying or in the sitting position. After the cavity has been evacuated one or two good-sized rubber tubes are placed in the cavity, medium depth, and fastened with a safety pin. The cavity is then irrigated every three or four hours with Carrel-Dakin solution. This can be done with a Carrel-Dakin tube or ordinary catheter. Temperature will drop within twelve to twenty-four hours and the patient tells you that he is very hungry. Contra-indications to Carrel-Dakin solution (1), I think, would be abscess that ruptured into bronchi, causing coughing; (2) too strong or too weak solution. Dichloramin-T solution has also been used in these cases, but with not as apparently good results as Carrel-Dakin solution. Dichloramin-T is a thicker fluid, therefore does not dissolve fibrous tags, and therefore does not produce as good a drainage as Carrel-Dakin solution. I have used

Carrel-Dakin solution in many cases, both in and out of the army, and never had trouble in but one case, and that case was a child five years old that was spitting up pus before I operated on him, and he would not stand much of the solution at a time before he would begin to cough.

Just when to let these wounds close up requires a great deal of judgment. Some use the organism smear count as an indicator; others say let the opening close when the lungs expand and fill cavity. I think no secondary operation, such as Schede, etc., should be attempted until the antiseptic solution has been given a thorough trial and tested out. Beck recommends his paste, 10 per cent, to be used in some of these cases where there remains a sinus. Dr. Willis has used it in a limited number of cases and has had good results. Technic is to inject the cavity full of paste, let alone for three or four days, then withdraw as much paste as possible and then reinject.

An article by Monzingo advocates, as many others do, a close method of treatment, and claims the following: (1)A simple early operation, without danger of shock or collapse of the lung; (2) intermittent removal of secretion and antiseptic treatment given through a small rubber syringe; (3) rapid partial sterilization with neutral solution of Carrel-Dakin solution, followed by 2 per cent formaldehyd in glycerin; (4) maintenance of negative pressure in the empyema cavity, tending to an early obliteration of the cavity; (5) one dressing will last several days, no skin irritation; (6) emphasis on simple physical principles rather than major operation. Where pus is present on both sides it is a better way to handle cases of empyema than by the open method.

In conclusion, we would like to say again: (1) That we believe that it is best not to operate on these cases as long as pneumonia is present; (2) to aspirate, if quantity of serous exudation is such as to interfere mechanically with respiration; and (3) operate only after pneumonia has subsided and fluid has become purulent, by intercostal drainage, or, better, by rib resection. We believe that if these rules are carried out that the death rate from empyema will be much lower.

Discussion of Dr. Garrett's Paper.

Dr. E. M. Ellis, Crowley: The late lamented, but illustrious John B. Murphy stated that the smallest boy could make an opening into the

thoracic cavity, but that it took a full-grown man to close it up. I have had quite a little experience in this work, and after resecting ribs and dressing wound and doing operation after operation and then have my patients slip away to some other fellows and get the wound closed up I got very much discouraged with the open method of treating adults for empyema. Of course, in a certain percentage of cases I must admit they do well, but there is another percentage that do not do well. It was only a few days ago that one of the returned soldiers came to me with a running wound in his side where he had a rib resected at the base hospital some six or eight months ago. He still has a discharge, and will have to have another operation. I believe if you take the majority of these cases in adults and treat them after Murphy's plan, aspirate them from time to time and give them an injection of formalin solution, you will sterilize the empyema cavity and avoid operation and get better results. I have preferred this almost exclusively in treating that character of cases. I believe in children the operation should be one of resection and drainage. They usually get well very readily—much more so than the adult.

Dr. H. J. Parsons, Shreveport: I consider one of the most important things in empyema is early diagnosis by the physician who sees the case. We have frequently seen cases of pneumonia which failed to clear up as they should on the eighth or tenth day, or that persisted, for some unexplainable reason, for a while. Later on I began to pay more attention to the physical signs and symptoms, and then I began to find out that early, before the fever had cleared up, some of these cases had developed an empyema, and there was a cause for the fever persisting. Some cases, where we have a false crisis in pneumonia, where the temperature goes down to normal, stayes twelve to twenty-four hours and comes back, these cases do not always mean a further extension of the pneumonia: they frequently mean the beginning of the formation of an empyema. I think it is very important that these cases be diagnosed early, because I am satisfied that a great deal of the trouble we have in closing these large cavities after pus formation is due to the fact that the lung does not expand after the cavity had been opened. The longer the lung is compressed the longer time is required for it to expand afterwards. The more pus we have there the more the lung is compressed. So, I believe the doctor who sees the case early should recognize it early and have the case operated as soon as possible.

I have seen cases of empyema due to other causes than influenza or pneumonia. I remember one typical case that followed a case of appendicitis in a child, who had a ruptured appendix, with the whole abdomen full of pus. A week afterwards there was a typical empyema, so we will have to be on the lookout for other septic conditions.

In regard to closing up a case of long standing, a good many years ago, after Dr. Beck published his researches along that line, I began to use bismuth paste, and following his early instructions I used 33⅓ per cent strength. I think the second case I tried it on developed a beautiful case of bismuth poisoning. Unfortunately, I did not see the child after the bismuth injection was made—they moved away, and I did not see the case in time to attempt a withdrawal of the bismuth. The child recovered, but since then I have used 10 per cent bismuth and I have never seen any further trouble. I am satisfied it is an aid in the closure of long-standing cases of empyema.

In regard to the Carrel-Dakin solution in irrigation, there must have been something wrong with our technic, because it certainly did not agree with the cases we tried it on following influenza. I followed the method instituted by Dr. Willis, and the solution was properly made, I am sure, but still, after the irrigation, the patient complained very much of pain and each irrigation was followed by a temperature of 102° to 103°, which temperature persisted as long as we irrigated. As soon as we quit, the temperature fell and the patient recovered.

(In closing, Dr. Garrett illustrated on the blackboard the two methods used in the army.)

VENEREAL CONTROL.*

By CAPTAIN HAROLD M. WILSON, Signal Corps, U. S. A.,

Assistant Director, Fifth District, War Department, Commission on Training Camp Activities.

The problem of venereal control is a civilian problem. The fighting man is always infected in civilian environments, and the problem in the army and in our camps has been to deal with cases which are the results of civilian environment. There is, therefore, before you a task for professional men, for hard-headed business men and for capable women. This paper does not purport to be a scientific essay, but I believe that it has a proper appeal to the scientific mind, in that it urges a campaign against an all-pervading evil which calls for the best efforts of every enlightened mind to check and defeat it.

As a military man I do not presume to insist that my branch of the service, the Signal Corps, has rendered more important service than the artillery, the infantry or any of the other various departments of the staff and line in the war against Germany, but this is certain: the omission of instruction, installation and maintenance of technical liaison would have proven a serious loss in our fighting efficiency—perhaps an irreparable loss. The carrying on of a campaign to the successful conclusion requires the coördination of all branches of the service, each playing an equally important and necessary part in the strategetic and tactical whole. In like manner, in the campaign against venereal diseases it is necessary to utilize to the full all available essential means of offense, defense, reconnoissance, communication, supply, intelligence, etc., and I venture to say that there can be no class of our civilian population which can render more valuable service in this fight than the medical profession.

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*Read before the Orleans Parish Medical Society, May 26, 1919. [Received for publication June 4, 1919.—Eds.]

You may be interested in listening to an extract from one of the pamphlets issued by the American Social Hygiene Association as a part of its propaganda of enlightenment, entitled "Fighting Venereal Diseases a Public Trust," by William H. Zinsser. He says, in part:

> "Venereal diseases are a civilian problem. Communities send their men out into the world educated as far as possible upon every problem except one. The subject of sex has been neglected in the home, in the school, and in the pulpit. The whisperings of the street loafer and the suggestive stories of so-called 'wiser' youths are the first impressions that the average person receives of life and sex relationship.
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> "And what are one's general impressions on this neglected subject, so shrouded in secrecy and false modesty, so mysterious as morbidly to attract—that prostitution is condoned; that attempts to cope with it are useless; that venereal diseases are not serious—in fact, the early youth often brags about them; that continence and health are incompatible; that what is expected of a woman is impossible for a man, and that the old story of wild oats, that must be sown before real manhood is attained, is indusputably true!"

Can we, therefore, blame the Army and Navy for putting their greatest cause of inefficiency squarely up to us civilians? In our military branches men are for the first time educated on subjects which should have been touched upon years ago. Thousands have entered the Army and Navy infected with syphilis and gonorrhea. These are receiving modern, intelligent medical treatment for the first time, because civilian communities have had no facilities in hospitals or dispensaries provided for them. These men have been allowed in civilian communities to spread their terrible ailments unchecked; the Army and Navy have done what the home towns of the enlisted men should have done. The men will be sent back cured when the war is over. Will the good work be undone, or will the evil of false pride and stupidity be torn aside now, when the opportunity of generations is before us?

The government soon realized the possibility of doing a great piece of constructive war work. Both the Army and the Navy adopted an extensive and comprehensive program to combat venereal diseases, based upon results studied in this country and abroad. The Federal law was strengthened by the addition of sections prohibiting the sale of alcohol to soldiers and by repression of prostitution. Local authorities in communities near Army and Navy camps were asked, and even compelled, to pass similar ordinances. State health departments succeeded in passing health laws on venereal

diseases which, in peace times, might have been put through only after years of missionary work—if at all. People began to realize, because of the extensive network being built up by the government, that this entire problem must be more serious than they had ever imagined, and that it was so deeply rooted that no half-hearted measures would suffice.

Before the war a comparative few had struggled manfully to combat prostitution and venereal disease, both camouflaged under the name of the "social evil," for fear of giving offense to the false modesty that existed on these subjects. The war, however, changed all this, as it has many things. Whatever else it will accomplish, it already has been the force that has driven these subjects from darkness into light, compelling attention and focusing public opinion squarely upon a situation that had always been held much too lightly and apathetically.

To-day people working on this subject are no longer "ahead of their time." They are no longer reformers and visionaries. They are suddenly considered courageous exponents of a too long-neglected problem. How much less courage it takes to-day to arouse interest and open discussion on this long-forbidden topic! The audience has increased until it numbers millions. Every family has a representative among our fighting forces. There is an intimate human point of contact now. It is no longer a question of reforming mankind, an altruistic principle. It is a question of saving a father, a husband, a son or some other dear relative from diseases and wounds far more dangerous, inheritable, transmittable and dishonorable than the scars of battle.

Knowing that its audience on this subject was keyed to a high pitch and only too anxious to be guided, the government decided to interest itself in this side of the civilian problem, to make suggestions whereby conditions could be improved and to recommend that the Army and Navy program be applied to civil life. The same principles hold true in the community. The same men are coming back from the war, and the people in their hometowns should see that the returning fighters are as scrupulously taken care of as when they were in the service of the government.

By August, 1917, the Surgeon General's office had perfected its plan for combating venereal diseases and immorality in the Army. Medical and educational methods were closely coupled with one an-

other. Lieutenant-Colonel William F. Snow, who had this particular program in charge, realized, from his intimate knowledge of the subject, that the time was ripe to plan national educational and constructive propaganda on this problem. Fathers and mothers wanted to know what the Army and Navy were doing for their own particular boy. The Army and Navy were just as anxious that the parents know in detail the steps the government had taken to safeguard their children. There was a double purpose in this. Civilians were being educated on the best methods known to combat a scourge that the draft had shown was very much more prevalent among them than in the Army.

A committee to obtain assistance from citizens, particularly from those residing within an accessible radius of training centers, was organized under the Medical Section of the Council of National Defense. This committee was called the Committee for Civilian Cooperation in Combating Venereal Disease, and during the last half of 1917 it dispatched thousands of letters to leading citizens in more than nine hundred communities situated within easy reach of the military or naval camps. Literature describing the government's program and suggesting ways for local action was widely distributed. Fathers and mothers were asked to become co-workers in the government's plan and to help keep their communities as clean as they would want that one to be near which their own particular boy was camped. Little by little newspapers helped take up the drive. The medical and sanitary officers in the various localities coöperated with the citizens (with or without their officials, depending on the attitude of the latter) to see that the soldier and the sailor were amply protected from vice. The government instilled the feeling that nothing is too good for the man who is going out to fight for those who cannot, and that the worst form of slander was the impression which seemed to prevail that every time an enlisted man was seen in uniform in the street he was out deliberately to mock existing regulations and to look for trouble. *The soldier or sailor will take a community as he finds it.* If the bad people outnumber the good in any community, as far as their attention to the man in uniform is concerned, there is very little chance for the soldier to escape. The great majority of men follow the path of least resistance.

The results obtained by this committee were so far-reaching that the government decided to establish a committee to educate women

and girls on this subject. It felt that the women were the builders of the home. They were sympathetic; they could touch upon this subject with boys and girls with possibly much greater success than the men. They could further help to solve the serious problem of warning the young girl whose patriotic ardor had almost made her hysterical in her relations with fighting men.

In order to concentrate all these movements under a single head, the Committee for Civilian Coöperation in Combating Venereal Diseases was transferred to the War Department Commission on Training Camp Activities. A new division, the Social Hygiene Division, was created. Educational work that had been done since the inception of the war among the soldiers and sailors was brought into this same division, closely linking up the work into three sections—a section of the Army and Navy work, a section on men's work, and a section on woman's work—with one leader, with one plan and with one purpose.

These three sections should be able to further a cause that strikes at the heart of things and to accomplish a work not only helpful to the country at this time through protecting its men in uniform, but to lay the foundation of a work that will increase through the ages and that will wipe out in this country a blight which a few years ago it seemed almost impossible to combat.

The system of arousing community interest employed from the outset was as simple and direct as it was effective. A list of the prominent doctors and lawyers and the most influential business men in a given city or town was carefully worked out. A letter detailing conditions and accentuating the urgent need for coöperation on the reader's part towards securing prompt, drastic measures repressing prostitution invariably secured the desired action. City officials suddenly realized that the best elements of the public were demanding a clean community. A later letter to the proper city official, usually the mayor, supplies the spark—swift, concerted action results. Official lethargy is replaced by official zeal. The War Department has spoken—the average community, large or small, replies.

By forcing the work along these lines, by coöperating closely with the Law Enforcement Division and its men in the field, the section on men's work has, in the short space of its official existence, reached over nine hundred communities, large and small. The list is rapidly increasing. Thousands of civilians have been written to; hundreds

of thousands of booklets and pamphlets have been distributed. The work is being extended as rapidly as conditions will permit.

Of greater importance than the closing of houses of prostitution and the strenuous combating of vice agencies is the question of public education. Public health clinics for the free diagnosis and treatment of venereal cases are becoming more numerous. They will form the very foundation of the great constructive phase of the work to be carried on as a definite public program for all time.

Publicity, propaganda—call it what you will—we must have it to-day; selling soap or social hygiene, it matters little. The public is sold easiest when it sells itself. Turn the batteries of intelligent information loose; put down a barrage of knowledge between the public and the agencies of vice and disease, and it will put to rout ignorance, hypocrisy, secrecy. The subject must be discussed. It is true that shame and venereal disease go hand in hand. But a greater shame is that an intelligent people have carefully avoided the slightest reference (except in the most guarded fashion) to the question.

Prostitution is an active menace to health, morality, prosperity, good government and self-respect. Prostitution and its inevitable companion, venereal disease, hangs over the head of every household like the sword of Damocles. Syphilis and gonorrhea are no respectors of persons, class or position. In a household where there are those who may be saved from actual contact of infection there is the threat, and more often its fulfilment, of shame, sorrow or degradation, through the misfortune of some loved one. What family is there that has not suffered in some form becauase of this, one of the greatest curses of humanity?

Prostitution, its prevention and restriction, have been studied for centuries, but never heretofore has there been made an actual fight against it from a purely scientific and practical standpoint. It has never heretofore been made a public health problem, and attacked officially through the recognized agencies and officers whose duty it is to preserve and conserve public health. Far be it from me to belittle the splendid efforts which have been made to solve this problem from a purely moral standpoint, nor should the moral aspect of this question be set aside, for it goes hand in hand with the educational campaign, the scientific campaign and the civic campaign which we are striving to bring to a successful standard. I am not

altruistic or visionary, and do not expect that any effort will result in complete extirpation of illicit sexual relations. Careful scientific study and experience, particularly the experience of this war, have shown that the old-fashioned methods of toleration, legal restriction and the like, are vicious, fallacious, non-economic, unsanitary, conducive to corrupt political partnerships and contrary to a sane right-minded public policy. There can be no better proof of this than to look behind the scenes and see who are the principal and most active proponents of license and legal toleration; to see who are they that lurk behind the purblind "respectables," those innocent and usually ignorant citizens who urge "sanitary segregation," "safety first," "you can't change human nature," "it is necessary for youth to have its fling," *ad nauseam*. If you look carefully into this camouflage of vice you will find disclosed those who are fighting for the conditions which have hitherto existed, the which conditions are responsible for the fact that the Army has lost during the war, more days of service on account of venereal diseases than from any other cause. Those who really and truly desire the return or maintenance of old conditions are the whores, the pimps, the unprincipled landlords, corrupt politicians who pander to the underworld for support, grafters, strong-arm men, "dips," "hop-heads," "red light cadets," crooked lawyers, crooked doctors, crooked druggists, dive-keepers, proprietors of cabarets, of assignation, bell-hops, taxi-drivers, proprietors of questionable hotels, race-track touts, gamblers and pious hypocrites. Is this not an imposing array? Then you may add to this vanguard those who are supine and indifferent, those who say, "Let George do it," that class who wanted this country to stay out of the war; those who wanted the districts maintained and prostitution to flourish in order that our Army might be crippled and the Hun have one more weapon in its fight against decency and civilization; the profiteer—and don't forget the pure shrinking violets to whom blissful or any other kind of ignorance spells innocence and purity. Also there is another unfortunate class who are led and swayed by the big underworld politicians—that curious, infamous anomaly of politics who sometimes can, for some mysterious reason which does credit to his sagacity, at least consort on terms of equality and familiarity with those who, under normal conditions, would kick him out of their homes, clubs and places of business. I refer to that type so frequently seen in American politics practicing the most vicious kind of politics. He bids for popu-

larity among the poor and ignorant by giving ostentatiously a certain percentage of his graft to the poor, is publicly charitable, gives picnics, boat-rides, balls, has associations named for him, is a "good fellow," always ready to help some one out of trouble, while his underlings drag down the sons and daughters of his followers to shame and degradation so that he, his pimps, thugs and "cadets" may gorge and grow fat on the spoils wrung from traffic in bodies and souls. These are the ones who are fighting true progress. There are some who are really "conscientious objectors"; there are others who are slackers, pacifists, traitors, spies, and, most respectable of all, open enemies.

What is the answer? Can there be any right-minded citizen who cares to ally himself, directly or indirectly, with any of these classes? Is there any professional, scientific man who is not willing to fight this evil with all his might and with all the power and prestige of his position and his science? It is indeed unfortunate that facts and figures tend to show that there is somewhere a reluctance on the part of some to align themselves with those who are fighting on the side of science and good government.

Permit me to quote you a few figures which may throw a light on the attitude of some of the doctors of the State of Louisiana. Being a member of the legal fraternity, I, of course, assume that you are familiar with the law, and it is axiomatic that ignorance of the law is not a legal excuse for non-compliance therewith. During the month of April, 1919, there were reported in the State of Louisiana, in conformance with the provisions of Act No. 61 of 1918, 127 cases of syphilis, 303 cases of gonorrhea and 18 cases of chancroid, a grand total of 448 cases reported. Of these, 294 were black and 154 white. If these figures truly represent the number of venereal infections in Louisiana during the month of April past, then I am prepared to admit that there were only two houses of prostitution running openly in the City of New Orleans during the month of March, 1919. I will go even further and admit that there were only two houses in the whole State of Louisiana.

Let us now compare these figures with others. The first million of the draft shows the State of Louisiana as standing No. 36 in the list of forty-eight States, with a venereal rate of thirty-three men out of every one thousand. In the second million draft, the rate jumped from thirty-three per thousand to 112. In the second million draft only four States had a worse record than Louisiana,

namely, Georgia, Florida, South Carolina and Mississippi. Alabama, Arkansas, Oklahoma and Texas complete the venereal black belt, each being over 10 per cent infected. In the second million, the City of New Orleans stands No. 48 in the list of fifty-seven cities of from 100,000 to 500,000 population, with a rate of 92.29 per thousand. More than 9 per cent infected. The letter from Washington which accompanied these figures says, among other things: "It is doubted whether the City of New Orleans and Louisiana will be proud of their record in 'going over the top' in this unenviable manner." These figures tell their own tale, and I venture to say they are not susceptible of the explanation, "Report not well founded." Ordinarily statistics are dull and uninteresting, but I believe that these which I have just quoted must appeal to the civilian population. All venereal disease in the Army is caused by conditions in civil life. As heretofore stated, the Army lost more days of service through venereal disease than through any other cause. From September, 1917, to September, 1918, there were 170,000 cases, which approximated a loss of two and a half million days of soldier usefulness. Just figure these costs: medical treatment, hospital equipment, time, then remember that for every one case contracted after draft or enlistment there were five contracted before enlistment; this clearly shows that most of these diseases came, not from cities near army camps, but from home towns and towns passed through on the way to camp.

Venereal diseases in the Army were 102 to the 1,000, while all other communicable diseases were about 29 to the 1,000. This great prevalence of venereal diseases was due largely to conditions in civil life. Army medical men have proved that venereal disease is largely preventable by education, healthy recreation, repression of prostitution, isolation and treatment. They have cut down venereal rates in camps. All these methods are applicable to civil communities, and civil communities can no longer evade the issue. These are the facts, and the government asks each member of the medical profession what he is going to do. The war is over and the protection of the returning soldier and sailor is your problem. Is your State accepting its reconstruction task? What part will you play in this task?

May I suggest, first and most important, a strict compliance with the law? The physicians of this State are licensed by the State, and by virtue of this license are permitted to do some things and

required to do others. One of these requirements is that you will report all venereal diseases to the State Board of Health. That law is well defined, and its compliance is essential and necessary, that intelligent effort may be made to check the spread of venereal diseases. If there be doubts of the constitutionality of this law, these doubts may only properly be resolved in the courts. If there be a question of professional ethics or personal liberty, these questions, if not based upon substantial legal grounds of objection, must give precedence to public health and welfare. If compliance with the law involves what seems to be too much extra work, sacrifice of time, it is unfortunate, but the law is mandatory. There is a legal method by which it can be so amended as to result in a minimum amount of extra labor and still lose none of its essential value. Let me further assure you that these reports are entirely confidential, and do not require the reporting of your patient by name unless the patient proves recalcitrant and refuses to continue proper treatment until discharged as cured. The figures given above for the month of April indicate the law is not being complied with in this State, unless, perchance, the sudden decrease of venereal disease during the month of April was caused by the fact that many of the prostitutes, for some inexplicable reason, worked only during the non-infectious hours of the day, namely, from 10 a. m. to 3 p. m.! If there is one good reason for the violation of this law I have yet to hear it.

The physician who does not obey this law in the spirit and the letter must needs class himself with the shyster lawyer, except that his offense against his profession and society is greater, for he insults motherhood and denies the right to those still unborn to a clean and honorable birth.

Compliance with the law is not all that physicians may do in this fight. Hospitals should be persuaded to admit venereal cases, so that the number of carriers may be minimized. Clinics are a valuable aid in this work. and physicians can be of tremendous service in advocating legislation for the establishment of such, and their services should be given freely in this work. The medical profession should continue with unabated vigor their efforts to put out of business quacks, advertising doctors and druggists who sell venereal disease nostrums without prescription.

Each member of the medical profession should understand the seriousness of statements frequently made that the majority of

physicians refuse to treat venereal diseases, and that many who do treat them are careless in their methods of treatment. As a result of the refusal of a large part of the profession to give the problem study and attention, venereal disease has become a head-liner for quackery and self-treatment. Your profession, gentlemen, can also educate people with regard to venereal disease and sexology. Get in touch with the State and City Boards of Health and coöperate with them in their educational campaign. Let the medical profession put its shoulder to all movements to bring proper treatment and industrial education to the prostitutes who can be rehabilitated, and for the care and permanent segregation of the feebleminded. Let the voice of your knowledge and experience be raised against the resumption of the folly of segregation and in the urge for the suppression of commercialized prostitution of all kinds.

Venereal disease is a scourge which menaces the industrial efficiency of a nation; it menaces motherhood and all that we hold dear. There can be no peace with prostitution, no truce with the red light district, no armistice with venereal disease. It is a fight to the finish, and the only finish which will satisfy humanity is an unconditional surrender.

PROCEEDINGS OF THE AMERICAN SOCIETY OF TROPICAL MEDICINE

MEETING, ATLANTIC CITY, JUNE 16, 17, 1919.

SOME PHASES OF TROPICAL MEDICINE IN THE RECENT WORLD CONFLICT.*

By C. C. BASS, M. D., New Orleans, La.

It will be many months, and perhaps many years, before all of the medical history of the recent world-war is recorded. Most, if not all, of the governments involved are compiling the data, but the task is so enormous that it cannot be completed soon. In fact, if completed, it would not be available until peace is finally signed.

*Presidential Address. Read at the Fifteenth Annual Meeting of the American Society of Tropical Medicine, held at Atlantic City, June 16 and 17, 1919.

It is not possible at this time to get a great deal of data that bears directly upon tropical diseases in the war. It will perhaps not be out of place, however, for us to begin to discuss some of the things that we do know, as a kind of preliminary to more extensive consideration whenever we have more facts and data.

Though the great battles were fought on fields not tropical nor favorable for tropical diseases, some of them were fought, and especially a good part of the campaigning was carried on, in countries where various tropical diseases prevail. Not only is that so, but as one nation after another came into the conflict there were finally gathered together in camps, on battle-fields and in other places great hordes of men, some of whom were drawn from the most tropical countries of the earth.

Regardless of the precautions taken against it, the haste incident to the great emergency and other imperfections that would not have been operative under more favorable conditions brought in many persons infected with the parasites of different tropical diseases. Though the sick could be eliminated, the carrier frequently could not. The carrier problem in many of the tropical diseases is more important that in other diseases. We have the malaria carrier, the hookworm carrier, the ameba carrier and many others. Many of them cannot be found out by the most careful examination that would be practical under the conditions of military necessity. Therefore those armies drawn from tropical countries must have brought with them many of the diseases most prevalent in the tropics.

As the war went on and extended it became necessary to send expedition after expedition from non-tropical countries into countries which were veritable hot-beds of tropical diseases. In many instances these forces consisted largely of men who had lived all of their lives in temperate climates and who possessed no acquired immunity or resistance against tropical diseases. Forces from England and France were sent into Macedonia, one of the greatest hot-beds of malaria on the face of the earth, and into Salonika and Gallipoli.

The story of the Dardenelles has not been told. The mouths are for the present closed of many of those who witnessed the havoc wrought by dysentery and wound infection among the gallant Englishmen and Anzacs, who were sacrificed to want of forethought and lack of administrative capacity to deal with the new conditions,

which required the administrator to get out of his rut. I refer especially to insufficient medical units, their poor equipment and, above all, their lack of authority.

It is not for me to criticize or to condemn. In such gigantic undertakings it is to be expected that mistakes will be made. It is remarkable, however, that some of the mistakes that were made would have been made even under the most pressing circumstances. Until and unless a truthful, detailed history is available of the causes of some of the deplorable conditions and great havoc wrought by tropical diseases, especially malaria and dysentery, we shall not be in position to know all of those who and what were at fault. The medical officers of the British forces, in which some of the most shameful and inexcusable prevalence of tropical diseases occurred, invalidating and killing hundreds and thousands of gallant soldiers at the time they were most needed, are outspoken in their claim that it was due largely to lack of authority given the medical corps. Col. Andrew Balfour[1] said, at a recent address at a meeting of the Society of Tropical Medicine:

"In common with you, I have the honor to belong temporarily to the Royal Army Medical Corps, and I have seen again and again how the efforts of that corps are frustrated by conditions dependent upon other departments. Too often it gets the blame when it is not blameworthy."

All through the early stages of the campaign in Mesopotamia malaria and dysentery were poorly guarded against. Men fell victims by thousands to malaria, dysentery and wound infection, while the Indian Medical Service officers and civilian practitioners with the army had to stand by, powerless to apply the preventive measures which they knew would have saved lives and lessened invalidism.

I am not in position to criticize either individuals or methods which led to the deplorable conditions with regard to tropical diseases in the Mediterranean area. It remains a fact, nevertheless, that these diseases were allowed to practically incapacitate and defeat these armies. Remember that malaria is one of the tropical diseases about which we know most and one which numerous demonstrations in different parts of the world have shown to be absolutely within our control. The epidemic of malaria that affected the armies operating in Macedonia forms, if not the most important, at least one of the most important epidemics in history. Not since the armies of Xerxes were decimated by malaria in that same region

has there been a situation comparable to these modern forces in these valleys and marshes.

There was apparent failure of prophylactic doses of quinin, according to the reports that have been available to me. Such details, however, as are needed to be convincing are not at hand. I am sure that many of you feel as I do—a little skeptical and uncertain in the absence of more definite information as to just what was done. The fact remains, however, that a very large percentage of all the men in these forces was infected. Different estimates vary greatly. Garin[2] claims that plasmodia can be found in the blood of 60 to 80 per cent of the troops returning from Macedonia. Abrami[3] states that from 85 to 95 per cent of the French Macedonian army were attacked by malaria, in spite of early quininization. Threadgold[4] found parasites in over 30 per cent of various units of a certain division in Macedonia. It is most remarkable that, according to his statement, taking daily doses of from five to thirty grains of quinin did not seem to affect the presence of parasites. He specifies a group of twelve men, all taking thirty to ten grains of quinin daily, all with vivax schizonts and gametes in their blood. This is most remarkable, in the light of the rapid disappearance of vivax parasites while patients are taking even moderate doses of quinin, as most of us have observed.

We are told that quinin prophylaxis failed to prevent the infection of the forces that went into the malaria-infested countries. Generally the statements are rather indefinite as to the amount of quinin taken, and many other details are lacking. We are not in position, therefore, to judge to what extent quinin was actually tried and proven to be a failure. This is one of the most important things, if true. If quinin does not protect against malaria, the fact should certainly be known and established. If it does protect, and can protect against malaria, then it is extremely unfortunate to have reports based upon supposedly insufficient information, but actually incomplete information, that quinin has been tried on an extensive scale and proven to be inefficient. In view of the experience of many others, in which quinin has been demonstrated apparently to furnish ample protection against malaria, it is especially important that we should not accept without reservation the reports of its inefficiency when tried in Macedonia and other malaria-infested countries during the war. We should hold an open mind, at least.

Another thing that might be mentioned just at this time, in connection with the apparent inefficiency of quinin to protect against malaria, which the experiences in the war, in certain quarters at least, seem to indicate, is the apparent inefficiency of quinin in the treatment of malaria. Large numbers of soldiers returning from Macedonia, infected with malaria, served as subjects upon whom different methods of treatment have been experimented with, in the Liverpool School of Tropical Medicine. A commission consisting of Lieut.-Col. J. W. W. Stephens, W. Yorke, B. Blacklock, J. W. S. Macfie, C. Foster Cooper and H. F. Carter, have published a long series of papers in the *Annals of Tropical Medicine and Parasitology,* giving the details of these experiments. The first of these papers appeared in Volume 11, No. 1, June, 1917. No attempt will be made here to relate and discuss the details of the experiments conducted nor the conclusions arrived at. The remarkable and astounding outstanding feature, however, has been the apparent demonstration that quinin in the doses and methods ordinarily employed does not disinfect infected persons nor prevent relapse. It appears from these experiments that, if quinin treatment is effective, it must be given in doses of as much as forty-five grains a day for at least two days out of the week. It is very remarkable that they were able to find parasites in the blood of patients who were taking large quantities of quinin, and who had been taking it for several days. Another remarkable thing they seemed to demonstrate is that a larger number of malaria-infected persons can be disinfected by giving forty-five grains of quinin on each of two successive days weekly than by giving the same amount daily.

Some of the findings by this commission are in such strong contrast to the experiences of many of us that I am sure that we shall have to wait for other evidence and experience before we are prepared to accept these findings as applicable generally. Who amongst us here has ever seen malaria parasites persist in the blood for days or weeks in the presence of even twenty or thirty grains of quinin a day?

It may be possible that the explanation of the apparently unusual findings of this commission rests very largely upon the fact that the subjects upon whom the experiments were made had been infected months before and had been unsuccessfully treated with improper methods, and had become much more resistant and difficult cases All of us have seen exceptional cases of malaria, that were

particularly difficult to disinfect. The selection of the cases in this way would likely lead to the use of resistant cases nearly altogether in the experiments referred to. The results of experiments on a group of all resistant cases would naturally be very different from the results upon cases as they occur ordinarily. For instance, in a community in this country where there are many persons infected with malaria there is comparatively only a small number of the resistant and especially difficult cases to disinfect. If we gathered them all together, however, and by experiment worked out a treatment that would be applicable to and would cure all of them, we would in all probability have a much more exacting treatment than would be required in ordinary cases. If this is not the explanation, then I do not know what it may be. One thing I wish to do is to warn against the idea that the results obtained in such a group of people, if found difficult and impractical, is not necessarily what would be required for ordinary purposes.

Another phase of tropical medicine that is brought out by the war is the possibility of spread of tropical diseases in countries where they have prevailed very little, if at all, before. Men returning from those battle-fields and campaigns, where they were infected with many tropical parasites, have been returned and are still returning to their homes. Perhaps the sick and those known to be infected are not released from observation and treatment, but what about the carriers? Hundreds and thousands of men affected with malaria, dysentery and other tropical parasites, not sick at the time of their discharge, are sure to carry these parasites into practically all parts of the civilized world.

In England,[5] where there has been no malaria transmission for many years, malaria has already begun to be transmitted. I have not the figures for 1918, but during the summer and autumn of 1917 there were at least 178 cases of malaria, undoubtedly contracted locally, in certain southeastern counties in England. Anopheline mosquitoes are known to exist in many parts of England and Wales. Whether there are localities in England where Anopheline mosquitoes are sufficiently abundant to give rise to much transmission of malaria remains to be seen. If such should be the case, there would be no great surprise if the disease should gain a foothold, and for the time at least spread and increase in England.

According to Leger and others,[6] before the danger was recognized several active foci had developed in France. There may be many

more foci than have been recognized. A commission was appointed to chart France with reference to where Anophelines exist, and malaria-infected soldiers returning from Macedonia are now sent to non-Anopheline districts. This is certainly a very clever way of handling the situation, but must be temporary. In the first place, they cannot be sent to and kept in these districts away from home for long periods of time. Naturally they will be discharged or allowed to go to other district as soon as they are supposed to be rid of their infection. Unfortunately, we have no method by which disinfection could be established beyond doubt. The inefficient prophylactic measures and methods of treatment carried out by the French medical officers in Macedonia and elsewhere permitted the infection to take place, showing their inability, it seems to me, to successfully combat malaria, should it become prevalent in France.

Even if those who are sent to non-Anopheline districts because they are known to be infected should be disinfected before they were allowed to leave, there would still be the carrier—persons who were infected, but were never recognized as such. No method of blood examination that is likely to be carried out finds all malaria carriers. It seems very certain, therefore, that malaria, dysentery, and probably other tropical diseases, must be scattered all over England and France and other countries.

Another tropical disease that was allowed to strike down many of the soldiers from non-tropical countries is amebic dysentery. It seems that bacillary dysentery was far the more important, but much amebic dysentery occurred also. Few people who get infected with pathogenic ameba are ever disinfected. They will be returned to their native lands ameba carriers, if not worse. Just as it occurred, following our Spanish-American War, that there was a great increase in the number of cases of abscess of the liver, so we may expect in England and France, and other countries where little amebic dysentery was formerly seen, to see a great increase.

One of the developments in connection with amebic dysentery in England as a result of the attention given to the infection in returning soldiers has been the discovery that *Ameba histolytica* is quite prevalent in natives in England. It has been found, according to recent publications by Yorke and others,[7] that *Entameba histolytica* is demonstrable in persons who have never been out of England in almost as large percentage of instances as in those who have been in the tropics, including even troops invalided home on

account of dysentery. This calls to mind the idea held by many that some other factor in addition to ameba is necessary to cause amebic dysentery. However the disease is caused, it remains a fact that ameba carriers are now being scattered throughout all the civilized countries. The presence of troops from the colonies in France and England, and the expeditions to Macedonia and elsewhere, have made amebic dysentery one of the prominent questions of the day because of the fact that it is liable to gain a foothold before its nature is suspected.

That it is possible to control tropical diseases under military conditions has been demonstrated in our own country. Large numbers of training camps and cantonments throughout the United States were conducted in such a manner, from a sanitary standpoint, that there was practically no Anopheles breeding within the camps, and therefore no opportunity for transmission originating there. The fact that large numbers of men, many of them carriers of tropical diseases, were brought together with large numbers of non-immune men from other parts of the country made it the more important that conditions should not be permitted to exist which would allow transmission to take place.

Large numbers of malaria carriers and hookworm-infected men were brought together in camps located in malaria territory. In many instances perfect sanitation of the camps would not have prevented the transmsision of malaria, because the sanitation extended only as far as the military zone extended. Fortunately, the United States Public Health Service coöperated to prevent mosquito-breeding in the extra-cantonment zones, consisting approximately of a zone one mile wide around the different camps. In many instances the camps were located in the most unfavorable places to do anti-mosquito work and where mosquitoes were most prevalent. In some instances at least—for instance, at Quantico, Va.—it would seem to those who look at it from the standpoint of health that the greatest disregard for this important feature of camp location was lost sight of. In a few instances at least, so far as I can learn, camps were unwisely located from this standpoint, without consultation with competent medical advice. Fortunately, the control measures put into effect by the Public Health Service in the extra-cantonment zones were sufficient to prevent any considerable transmission of malaria taking place, in spite of the fact that some camps were so unwisely located.

In some instances they were located in places where any competent authority on tropical diseases, especially malaria, would have advised that they should not be. Though there was always cordial coöperation between the medical officers of the army and the Public Health Service, insufficient consideration was given to the opinion of either of them, especially with reference to the prevention of this particular tropical and semi-tropical disease, malaria.

This brings me to the idea that I should like to leave with you, and that is that, for some reason or other, those who have been engaged in the investigation of tropical and preventable diseases have not commanded sufficient recognition for their opinions. I cannot say whether it is because we have not learned enough about tropical diseases or whether we have failed to bring the knowledge we possess to the attention of others, or whether there is some other fault, but it remains a fact, nevertheless, that during the present war there has been great neglect of some of the things we have known about tropical diseases for many years. The very fact that England and France have sent armies into countries known to be infested with malaria, and had them stricken down by the thousands by one of the tropical diseases about which we know most, absolutely preventable and controllable, and that they are now returning to every part of the country carriers of tropical diseases, shows that there is something wrong.

Even we, with our recent experience in the Spanish-American War, where it was demonstrated that certain tropical diseases, malaria and dysentery especially, if alllowed to run their course, were absolutely masters of the situation, and with our recent demonstration to the world of the accomplishment of a great engineering feat, constructing the Panama Canal, depending for success absolutely upon controlling certain tropical diseases, even with this experience we were negligent. I think those of us who are engaged in the study of tropical diseases should take a hint and see if we cannot remedy it if the fault rests with us, which I am afraid it does to a great extent. Is it possible that we have not advanced to the place where all people of civilized countries realize that, whenever undertaking any task in which tropical diseases are likely to dictate the results, they can and should consult and follow the advice of those who are informed? It is not that our medical officers—and medical officers throughout the world—were not, many of them, prepared to give proper advice, but the evidence at present

is that it was not sought as often as it should have been. Whenever sought, in many instances its full importance was not appreciated.

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TRANSACTIONS OF THE AMERICAN SOCIETY OF TROPICAL MEDICINE

The fifteenth annual meeting of the American Society of Tropical Medicine was called to order on Monday, June 16, 1919, at the Odd Fellows' Hall, South New York avenue, Atlantic City, N. J., with the President, Dr. C. C. Bass, in the chair. Dr. S. K. Simon served as Secretary, in the place of Dr. Swan, who was still absent on military duty.

The following members were present: Dr. D. Rivas, Philadelphia; Dr. H. J. Nichols, Washington; Dr. C. Y. White, Philadelphia; Dr. H. R. Carter, Baltimore; Dr. W. H. Seemann, New Orleans; Dr. Juan Guiteras, Havana; Dr. Clara S. Ludlow, Washington; Dr. Victor Heiser, New York; Dr. L. O. Howard, Washington; Dr. J. H. White, New York; Dr. Isadore Dyer, New Orleans.

The guests included: Dr. G. W. Woods, Washington; Dr. J. Labredo, Havana; Dr. Weneslao Pareja, Ecuador, and a number of others.

The President presented his address, entitled *"Some Phases of Tropical Medicine in the Recent World Conflict."* No Discussion.

A paper on *"The Surgical Treatment of Typhoid Carriers,"* by Drs. H. J. Nichols, J. Simmons and C. O. Stimmel, was read by Dr. Nichols. This paper was discussed by Dr. R. Rivas and Dr. H. J. Nichols.

A paper entitled *"Tropical Resources and Hygiene"* was presented by Dr. D. Rivas, Philadelphia. Drs. Juan Guiteras, L. O. Howard and D. Rivas took part in the discussion.

Miss Clara S. Ledlow, Washington, read a paper entitled *"One Phase of the Mosquito Work Connected with Army Camps in*

1918," which was discussed by Drs. H. R. Carter, L. O. Howard and C. S. Ludlow.

The final paper of the first day's session was read by Dr. D. Rivas, and had for its subject *"The Treatment of Malaria, with Special Reference to the Dose of Quinin, the Time and Mode of Administration, and the Length of Treatment."* This paper was discussed by Drs. H. J. Nichols, W. H. Seemann, V. C. Heiser, H. R. Carter, C. C. Bass and D. Rivas.

The paper of Dr. John L. Todd, of McGill University, of Montreal, Canada, entitled: I. *"The After Treatment of Trypanosomiasis in Africa,"* II. *"Concerning Immunity to Human Trypanosomiasis,"* was read by title.

Following the scientific section the President suggested a short executive session, to obtain the sentiment of the general membership of the Society in regard to several important matters which were pending. The first matter discussed was the proposal that had been made to change the name of the Society to the American Society of Tropical and Preventive Medicine. Dr. Rivas also suggested the advisability of the name, "Pan-American Society of Tropical Medicine and Parisitology." In the discussion, the point was stressed that a change of name might not be acceptable to the Congress of American Physicians and Surgeons. The question was finally laid on the table without action.

A report from the Committee on Bulletin was read by the Secretary. The committee recommended that, in view of the financial condition of the Society at the present time, no attempt be made to publish an independent bulletin of the transactions for the coming year. The report was ordered receieved. Dr. Isadore Dyer stated that the NEW ORLEANS MEDICAL AND SURGICAL JOURNAL would be inclined to meet the Society upon a fair and equable basis if allowed the privilege of publishing the transactions during the coming year. Several suggestions were made by the members present, and the entire matter was finally referred to the Council for action.

The President asked for an expression of opinion in regard to the remission of dues in behalf of absent members serving in the ranks during the war. This was likewise, after discussion, left to the discretion of the Council.

The meeting then adjourned.

MINUTES OF THE COUNCIL MEETING.

The meeting of the Council was held on Monday, June 16, 1919, at 10 p. m. at the Hotel Traymore, Atlantic City, N. J. Drs. C. C. Bass, H. J. Nichols and S. K. Simon were present. Drs. J. H. White, Victor C. Heiser and D. Rivas also were present as invited guests.

The minutes of the last Council meeting were read and approved.

Dr. C. C. Bass, as President, reported that he had appointed Dr. S. K. Simon as acting Secretary and Treasurer, in place of Dr. Swan, who had entered the military service.

The President likewise related the causes that led up to the postponement of the meeting of the Society at Asheville during November, 1918.

The acting Secretary and Treasurer read a report of the activities of his office, which was ordered received.

The Auditing Committee, composed of Drs. V. C. Heiser and W. H. Seemann, previously appointed by the President, reported that they had found all balances correct. Their report was approved.

The Secretary read the names of the following members who had resigned during the past two years: Dr. W. A. Korn, Dr. Jos. McFarland, Dr. J. Chalmers Da Costa, Dr. J. R. Hurley, Dr. Carroll Fox, Dr. Isaac W. Brewer. These resignations were accepted by the Council.

In regard to the matter of remission of dues to those members who had been in active military service, the Treasurer was instructed to notify these members that their dues would be remitted during the period of active military service if written request were made to that effect.

The following proposals for active membership were acted upon favorably: Dr. M. L. Graves, Galveston, Texas; Dr. Joseph Sailer, Philadelphia; Dr. Harvey C. Barnett, Charlotte, N. C.; Dr. Mark F. Boyd, Galveston, Texas; Dr. Joseph Leidy, Philadelphia; Major C. A. Kofoid, New York; Dr. P. L. Querens, New Orleans.

The following were proposed for corresponding members and approved: Dr. Alexandrino Padreso, San Paulo, Brazil; Dr. Mario G. Labrado, Havana, Cuba; Dr. Wenes Lac Pareja, Guayaquil, Ecuador; Dr. Vital Brazil, Brazil.

As honorary member, Dr. Carlos Chagas, Brazil.

Dr. D. Rivas presented the report of the committee appointed at the last meeting of the Society to obtain a larger membership among those interested in tropical medicine in the Latin Americas. Two hundred and sixty men, in all, had been communicated with, some of whom had signified willingness to become members of the Society. In view of the fact that many of the men communicated with had not as yet had opportunity of replying, it was decided to postpone final action upon these applications until the next annual meeting. Dr. Rivas and his committee were given a vote of thanks in behalf of the Society.

The following change in the By-Laws was proposed, and will come up for final action at the next annual meeting: That Article 2 of the By-Laws be amended to read as follows:

"The regular dues shall be paid by active and corresponding members. Honorary members shall be exempt from dues."

In view of the stringent financial condition of the Society at the present time, the Treasurer was requested to institute a vigorous policy in regard to delinquent membership dues. Those members who remain in arrears for three consecutive years, without adequate excuse, will in the future be dropped by the Society.

It was recommended that the Secretary make suitable arrangements with the NEW ORLEANS MEDICAL AND SURGICAL JOURNAL to continue the publication of the transactions of the Society for the coming year upon some equable basis. It was to be understood with the JOURNAL that such arrangement would continue only until the next annual meeting.

The report of the special Committee on Bulletin was ordered received and the committee was discharged.

The following officers were elected for the coming year: President, Dr. Henry J. Nichols, Washington, D. C.; vice-president, Dr. John M. Swan, Rochester, N. Y.; vice-president, Dr. Karl F. Meyer, San Francisco, Cal.; secretary, Dr. Sidney K. Simon, New Orleans, La.; assistant secretary, Dr. Allen J. Smith, Philadelphia, Pa.; treasurer, Dr. Sidney K. Simon, New Orleans, La.

Councilors—To serve three years, Dr. C. L. Furbush, Philadelphia, Pa.; to serve four years, Dr. V. G. Heiser, New York, N. Y.; to serve five years, Dr. J. H. White, Washington, D. C.

New Orleans was selected as the location for the next annual meeting. Adjourned.

The second scientific session of the Society was called to order by the President, Dr. C. C. Bass, at 9:30 a. m. on Tuesday, June 17, 1919, at Odd Fellows' Hall. Twenty-six members and a number of guests were present.

The President requested the Secretary to read the report from the Council. This report contained a summary of the various resolutions and motions passed by the Council at its meeting, which was held the preceding evening. The nomination of officers for the ensuing year was likewise presented. Upon motion duly seconded, the recommendations of the Council were approved in full.

The President then announced that the subject of the morning's program would be a *"Symposium on Yellow Fever."*

Dr. Charles A. Elliott, Chicago, read the first paper, *"The Clinical Manifestations of Yellow Fever as Observed in Guayaquil in 1918"* (lantern slide demonstration).

The next paper was presented by Dr. Hideyo Noguchi, New York, who spoke on *"Experimental Studies in Yellow Fever"* (lantern slide demonstration).

Dr. Weneslao Pareja, Guayaquil, Ecuador, submitted a paper entitled *"A Brief Account of Yellow Fever in Guayaquil,"* which was read by Dr. Juan Guiteras.

The paper of Dr. Mario J. Labredo, Havana, entitled *"Consideration of Dr. Noguchi's Publication of Experimental Work on Yellow Fever,"* with further notes appended, was likewise read by Dr. Guiteras, at the author's request.

Dr. Juan Guiteras, Havana, then read a paper of his own, entitled *"A Report on Epidemic Jaundice at Barbados."*

These papers were discussed by Drs. J. H. White, H. R. Carter, H. Noguchi, Weneslao Pareja, M. J. Labredo and J. Guiteras.

After this discussion the symposium was completed by the reading of the following two papers, *"The Mechanism of the Spontaneous Elimination of Yellow Fever from Epidemic Centers,"* by Dr. H. R. Carter, Baltimore, and *"The Eradication of Yellow Fever in the Tropics,"* by Dr. J. H. White, Washington.

A further paper on *"Blood Pressure in Yellow Fever,"* presented by Dr. J. Birney Guthrie, of New Orleans, was read by title.

Owing to the lateness of the hour, the papers of Drs. Carter and White were only briefly discussed.

Adjourned.

REPORT OF THE SECRETARY.

To the President and Councilors of the American Society of Tropical Medicine:

Gentlemen—Your acting Secretary wishes to submit the following report of the activities of his office:

In the early part of January, 1918, I was requested by the President, Dr. C. C. Bass, to take charge of this office, owing to the enforced absence of Dr. John M. Swan, who had volunteered for military duty overseas. Dr. Swan turned over all of the records in a well-kept condition, and otherwise assisted generously up to the time of his departure for the war area.

According to resolutions passed by the Council at the last annual meeting in New York City, the Society was to have met at Asheville, N. C., during November, 1918, in conjunction with the meeting of the Southern Medical Association. All arrangements had been made for this meeting, including a well-filled program, when, on account of the severity of the influenzal epidemic prevailing at that time, postponement was ordered by the President. Though we have received a cordial invitation from the Southern Medical Association to hold a meeting with them again next November, the assembling of the Congress of American Physicians and Surgeons at this time has made it impossible to postpone the 1919 session until then.

The membership of the Society at the present time consists of the following:

Active members	123
Honorary members	35
Corresponding members	17

During the time that has elapsed since the annual meeting of two years ago the following members have resigned: Dr. W. A. Korn, Dr. J. Chalmers DaCosta, Dr. Joseph McFarland, Dr. J. H. Hurley, Dr. Carroll Fox, Dr. Isaac W. Brewer.

Death has claimed three of our members during the same period, namely: Dr. Ramon Guiteras, Dr. Samuel S. Dixon, Dr. F. M. Sandwith.

Some of the members who had been in active service during the period of the war have asked the privilege of a remission of dues covering that time. The matter of granting their request, as well as the shaping of a general policy to cover the disposition of the dues in the case of all who entered military service, is referred to you for your consideration.

The Committee on New Membership, under the chairmanship of Dr. D. Rivas, which was appointed by the President at the last annual meeting, has been very active during the past year. Your acting Secretary has assisted in every way possible to further the plans of this committee. A report will be submitted by Dr. Rivas himself, outling the results of the activities of this committee.

There is likewise before you for consideration a report from the Committee on the Publication of the Bulletin, of which Dr. Isadore Dyer is chairman. The entire subject-matter regarding the publication of the transaction of the Society must be carefully considered at this meeting.

I wish to call attention to the good services rendered by the chairman of the Arrangements Committee, Dr. C. Y. White, of Philadelphia,

in obtaining suitable quarters for our present meeting, and would ask that a special vote of thanks be accorded him for his efforts in behalf of the Society.

Respectfully submitted,

(Signed) SIDNEY K. SIMON, Acting Secretary.

TREASURER'S STATEMENT.

STATEMENT FOR 1918.

1819.

Receipts.

Jan. 7, 1918.	Received from Dr. Swan, Treasurer for General Fund:		
	By New York draft	$ 96.16	
	Additional dues from membership, 1918	316.00	
			$412.16

Disbursements.

1918.			
Jan. 1.	John W. Swan (postage stamps)	$ 3.00	
Feb. —.	Exchange	.10	
Feb. 27.	New Orleans Medical and Surgical Journal	200.00	
	Exchange	.05	
May 17.	Total exchange	.40	
Aug. 31.	New Orleans Medical and Surgical Journal	100.00	
Oct. 2.	New Orleans Medical and Surgical Journal (envelopes, stamps and stationery)	17.63	
Nov. 13.	Tulane Press (printing)	2.25	
	Total exchange	.50	
			$323.93
	Balance on hand January 24, 1919		$88.23

STATEMENT FOR 1919.

1919.

Receipts.

Jan. 24.	Balance as per book	$ 88.23	
	Dues from membership up to June 1, 1919	252.00	
			$340.23

Disbursements.

Feb. 7.	Stenographer's fees	$ 25.00	
Nov. 12.	New Orleans Medical and Surgical Journal	150.00	
Nov. 24.	Tulane Press (printing)	16.50	
June 1.	Total exchange on checks	1.65	
		$193.15	
Balance on hand June 1, 1919		$147.08	
Library Fund		30.83	
	Total resources at present date	$177.91	

The following accounts are submitted for your approval:

New Orleans Medical and Surgical Journal, membership subscriptions, 1918-1919	$250.00
Stenographer's fees, January 1 to June 1, 1919	15.00
Acting Secretary, for stamps	19.06
Tulane Press (printing programs)	4.25
	$288.31

(Signed) SIDNEY K. SIMON, Acting Secretary.

LOUISIANA STATE MEDICAL SOCIETY NOTES

REPORT OF THE HOUSE OF DELEGATES TO THE GENERAL ASSEMBLY, APRIL 10, 1919.

The House of Delegates begs to report that four meetings of the Society were held, during which all the business of the Society was transacted.

The minutes of the various meetings held during the year by the several committees were approved, as were also the reports of the officers.

Tribute was paid to Dr. E. W. Mahler for the success of his work in the passage of the Medical Practice Act.

By motion carried, the Committee on Employees' Compensation was given the title of "Committee on Industrial and Economic Relations to Medicine."

A committee, consisting of the incoming President and Secretary, was appointed to revise the Constitution and By-Laws and issue a new edition for circulation among the members.

A communication from Dr. P. T. Talbot, Secretary, regretting his absence on account of foreign military duty, was read and filed.

A motion was carried to amend the By-Laws so as to make the Chairman of the House of Delegates *ex-officio* member of the Executive Committee.

The following amendment to the Constitution, recommended by a special Committee on Program in its report of April 7, 1919, was approved:

"The scientific program of each meeting shall be divided into two principal divisions, namely: Medicine and its allied branches, and surgery and its allied branches. These two main subdivisions shall be further subdivided into the following sections, each section having the specified number of papers, as follows:

Medicine and Allied Branches.

Medicine and Therapeutics	10
Pediatrics	3
Nervous Diseases	3
Bacteriology and Pathology	3
Public Health and Sanitation	5—24

Surgery and Allied Branches.

General Surgery	10
Gynecology and Obstetrics	4
Eye, Ear, Nose and Throat, including Stomatology	5
Genito-Urinary and Rectal Diseases	2
Dermatology	2
Radiology	3—26

"The President shall appoint the chairmen of the various sections not later than six months following his election, and these chairmen shall submit all titles of papers not later than sixty days prior to date of annual meeting."

The Society went on record as protesting against the increase in Federal tax on narcotics, and a motion was carried that the Society apprise its Representatives in Washington of this fact, and also that it ask the American Medical Association to present this matter to its individual bodies.

The following resolutions were adopted:

"Whereas, the United States Public Health Association will meet in New Orleans in the early part of October of this year; and,

"Whereas, this organization represents the largest and most important aggregation of men concerned in health conservation;

"Be it resolved, That the Louisiana State Medical Society gladly looks forward to the benefits to be derived from this meeting and most earnestly requests that its members become members of the American Public Health Association, and, whether they do so or not, at any rate to attend the meeting."

"Whereas, the ladies, the medical profession, the Mayor and City Commissioners, the Chamber of Commerce, the Provident Association, the North Louisiana Sanitarium, the Shumpert Sanitarium, the Highland Sanitarium, the various hotels and the press have left nothing undone to make the meeting of the Louisiana State Medical Society most pleasant and profitable;

"Be it resolved, That the deepest thanks be extended on behalf of the Society to all concerned for their gracious and untiring efforts to make our stay in their midst most profitable."

"Whereas, the State Board of Medical Examiners, as represented by its executive officers, has been watchful and earnest in the discharge of its duties;

"Be it resolved, That the Society commend the past course of the Board and pledges its wholehearted support to the Board in the continued discharge of its duties."

"Whereas, Our membership has so loyally and spontaneously responded to the needs of the nation during the war, both in civil and military capacities,

"Be it resolved, That the Society expresses its pride in their expected, but no less appreciated, response to the call of duty."

"Whereas, the officers and the clerical force of the Society have been so untiring and successful in their efforts to maintain the strength and standing of our societies during the troubled times just past,

"Be it resolved, That the thanks of the Society are extended to our retiring officers and the office force for their unfailing devotion to our beloved Society."

The following officers were elected: Dr. L. E. Henry, Lecompte, president; Dr. C. P. Gray, Monroe, first vice-president; Dr. S. C. Barrow, Shreveport, second vice-president; Dr. T. J. Dimitry, New Orleans, third vice-president; Dr. P. T. Talbot, New Orleans, secretary (in service); Dr. E. W. Mahler, New Orleans, acting secretary; Dr. H. E. Bernadas, Chairman House of Delegates.

Councilors: Dr. P. J. Gelpi, New Orleans, Councilor, First Congressional District; Dr. H. Dupuy, New Orleans, Councilor, Second Congressional District; Dr. B. W. Smith, Franklin, Councilor, Third Congressional District; Dr. J. E. Knighton, Shreveport, Councilor, Fourth Congressional District; Dr. J. L. Adams, Monroe, Councilor, Fifth Congressional District; Dr. Clarence Pierson, Jackson, Councilor, Sixth Congressional District; Dr. E. M. Ellis, Crowley, Councilor, Seventh Congressional District; Dr. S. J. Couvillion, Moreauville, Councilor, Eighth Congressional District.

COMMITTEES.

Scientific Work—P. T. Talbot, Chairman; C. V. Unsworth, W. J. Durel.

Public Health—T. A. Roy, Mansura; Louis Abramson, Shreveport; M. W. Swords, New Orleans.

Publication—P. T. Talbot, Chairman; J. E. Knighton, Shreveport; A. Granger, New Orleans.

Memorial—W. H. Seemann, New Orleans; J. A. O'Hara, New Orleans; A. E. Fossier, New Orleans; J. N. Thomas, Pineville; R. G. Holcomb, Lake Charles.

Medical Defense—J. C. Willis, Sr., Shreveport; H. Leidenheimer, New Orleans; P. T. Talbot, Chairman.

Health and Public Instruction—W. H. Robin, New Orleans; W. H. Knolle, New Orleans; T. A. Roy, Mansura; C. Chassaignac, New Orleans.

Cancer Research—A. Granger, New Orleans; Wm. Harris, New Orleans; H. B. Gessner, New Orleans.

Hospitals—J. N. Hendricks, Shreveport; D. J. McAnn, Atkins; J. L. Adams, Monroe; R. O. Simmons, Alexandria.

Budget and Finance—H. E. Bernadas, H. W. E. Walther, F. J. Chalaron, New Orleans; A. A. Herold, Shreveport; H. A. King, New Iberia.

Industrial and Economic Relations to Medicine—Isidore Cohn, Chairman; A. E. Fossier, W. H. Block, Geo. Roeling, New Orleans.

Medical Education—W. H. Knolle, New Orleans, Chairman; J. E. Knighton, Shreveport; Carroll W. Allen, New Orleans.

Hospital Standardization—R. O. Simmons, Alexandria, Chairman; J. C. Willis, Sr., Shreveport; H. W. Kostmayer, New Orleans; J. A. Estopinal, Arabi; Isadore Dyer, New Orleans; L. Abramson, Shreveport; C. P. Gray, Monroe, E. W. Mahler, New Orleans.

Legislation—Clarence Pierson, Jackson, Chairman. (Full committee not yet appointed.)

Journal—P. J. Gelpi, New Orleans, Chairman; Homer Dupuy, T. J. Dimitry, New Orleans.

Delegates to A. M. A.—W. H. Seemann, New Orleans; Clarence Pierson, Jackson.

NEWS AND COMMENT

AMERICAN MEDICAL ASSOCIATION'S NEW OFFICERS.—At the annual meeting of the American Medical Association, held in Atlantic City, June 9-13, 1919, the following officers were elected for the ensuing year: President, Surgeon-General William C. Braisted, U. S. N.; first vice-president, Dr. Daniel L. Edsall, Boston; second vice-president, Dr. Emery Marvel, Atlantic City; third vice-president, Dr. Eugene S. Talbot, Decatur, Ill.; fourth vice-president, Dr. Geo. Kress, Los Angeles; reëlected secretary, Dr. Alexander R. Craig, Chicago; reëlected treasurer, Dr. William A. Pusey. The next convention will be held in New Orleans.

THE OKLAHOMA STATE MEDICAL ASSOCIATION held its annual meeting in Muskogee, May 20-22, and elected the following officers: President, Dr. J. W. Duke, Guthrie; secretary, Dr. Claude Thompson. The next meeting will be held in Oklahoma City in 1920.

MEDICAL MEN HONORED BY YALE.—At the 219th commencement, on June 18, 1919, Yale University awarded the honorary degree of master of arts to Col. Samuel Hosea Wadhams, Medical Corps, Army General Staff, and the honorary degree of doctor of science to Col. Harvey Cushing, neurological expert of the army. There were two experts in public health among the graduates.

WASHINGTON UNIVERSITY MEDICAL SCHOOL TENDERED LARGE SUM.—The General Education Board has tendered Washington University School of Medicine the sum of $150,000, on condition that an equal amount be raised by subscription. This fund is to be used for the endowment of the department of pharmacology.

AMERICA NOW MAKES COLLODION.—To the list of medicinal and laboratory products formerly imported from Germany and now manufactured in this country must be added collodion, the lack of which for a time was a matter of serious concern to laboratory workers in histology, pathology and embryology.

CHINESE HOSPITAL IN FRANCE.—According to the *American Journal of Public Health,* the largest hospital in the world exclusively for Chinese is not in China, but in France. It serves the 140,000 laborers and other Chinese who have been brought to France during the war.

CANCER STUDY IMPEDED BY SHORTAGE OF MICE.—Because of the shortage of mice, and also because many physicians were taken from research work, cancer study during the war has been impeded, according to the report of Dr. Francis Carter Wood, Director of the George Crocker Special Research Fund of Columbia University. Mice, which breathe rapidly and are far more sensitive to gases than human beings, were used in large quantities by the Allied Armies for the detection of gas and the diagnosis of certain types of disease.

THE MISSISSIPPI STATE MEDICAL ASSOCIATION held its annual meeting in Hattiesburg, May 14, and elected the following officers for the ensuing year: President Dr. F. J. Underwood, Aberdeen; secretary, Dr. I. M. Dye, Clarksdale; treasurer, Dr. J. M. Buchanan.

THE AMERICAN MEDICAL EDITORS' ASSOCIATION, at its Golden Anniversary meeting in Atlantic City, June 9 and 10, under the presidency of Dr. George W. Kosmak, of New York, elected the following officers for the ensuing year: President, Dr. Seale Harris, Birmingham, Ala.; first and second vice-presidents, respectively, Dr. Franklin H. Martin, Chicago, and Dr. H. S. Baketel, New York; secretary, Dr. Joseph McDonald, Jr. Executive Committee: Dr. George W. Kosmak, New York; Dr. E. H. Lewis, New York, and Dr. D. S. Fairchild, Clinton, Iowa.

BEQUESTS TO MEDICAL COLLEGES AND HOSPITALS.—By the will of the late Dr. J. Ewing Mears, of Philadelphia, the sum of $100,000 is bequeathed to Harvard University for the study of methods to reform and cure criminals and mental defectives by surgical means; the sum of $5,000 to Jefferson Medical College for a free scholarship; $8,000 to the Rush Hospital for Consumption and Allied Diseases, for free beds in Memory of Frances B. Tyson; $2,000 to the Pennsylvania Training School for Feebleminded Children at Elwyn, Pa.

GERMANS DROPPED FROM MEMBERSHIP.—At the annual meeting of the American Medical Association in Atlantic City, June 17, it was unanimously voted to drop all German and Austrian honorary fellows from its roll of membership.

NEW REGULATIONS GOVERNING THE SALE OF ALCOHOL.—On June 30 the Bureau of Internal Revenue issued regulations governing the sale of alcohol for medical purposes. The regulations state

that physicians may prescribe wines and liquors for internal use or alcohol for external use, but in every such case each prescription shall be in duplicate and both copies be in the physician's handwriting. The quantity prescribed for such a patient in a given time shall not exceed one quart. In no case shall a physician prescribe alcoholic liquors unless the patient is under his constant supervision. All prescriptions must indicate clearly the patient's name, street address and apartment number, if any, the date when written, the condition or illness for which prescribed and the name of the pharmacist to whom the prescription is to be presented. Similar detailed restrictions for the sale of alcohol by drug stores have also been promulgated.

VOCATIONAL BOARD TO ENLIST PHYSICIANS.—Major J. R. McDill, chief medical officer of the central office of the Federal Vocational Educational Board at Washington, has decided to increase the medical staff of the board, and competent physicans are to be selected in all centers of population in the States of Mississippi, Alabama and Louisiana to coöperate with the board. A recent amendment to the act which created the board places the entire responsibility of determining the physical condition of applicants for training upon the Federal Board, making the function of the board half medical and half vocational. Major McDill states that about 240,000 men had beeen discharged from the service with disabilities since the war started and that there are 40,000 men in the military hospitals of the United States. So far, the board has put 4,500 men in training and there are 10,000 more ready to train. Specialists in every line of medicine will be called upon to help, and contracts with hospitals in every center are being made to take care of cases. According to Major McDill, the work of the board in New Orleans is progressing very satisfactorily.

THE SEMI-ANNUAL EXAMINATION OF THE LOUISIANA NURSES' BOARD OF EXAMINERS was held in New Orleans and Shreveport, June 23 -24. Thirty-one applicants qualified as registered nurses. The successful applicants are: Misses Eva Lenora Abbott, Felvia Adair, Angela Josephine Allen, Cornelia Anderson, Lillian Mary Bentz, Louise Broussard, Madie M. Butler, Maud Buttner, Carrie Bisland Cage, Susie May A. Collins, Mrs. J. Florian Cox, Mrs. Maude Crossett, Misses Effie Davis, Sadie Drake, Mrs. F. P. F. Duffy, Misses Mary Ellen Frost, Margaret Glover, Annie Greer,

Meta Grimshaw, Lillian M. Ham, Sister Martina, Sister M. Serena McCafferty, Misses Bertha Moffet, Mae Eulalia Moran, Sister Alicia Murphy, Misses Ella R. Newman, Agnes Hazel Oechsner, Gertrude Pitts, Gertrude Lee Roberts, Esther Schultz, Mrs. Martha Janke Scott, Misses Ella A. Simmons, Olivia Bernice Starks, Alice Gretchen Treen, Mrs. Carrie McCall Vincent, Misses Gladys Ione Whittington, Gussie Wright, Mrs. Mattie Barthe Wynn, Bessie B. Shortt. The Louisiana Nurses' Board of Examiners is composed of the following: Dr. J. T. Crebbin, president; Dr. J. S. Hébert, acting secretary-treasurer; Dr. C. A. Bahn, Major, M. C., Army Educational Commission; Dr. G. S. Brown, Dr. F. J. Frater, Shreveport. Dr. Crebbin has just returned from the national convention of the League of Nursing Education in Chicago, where it was stated that the Louisiana Nurses' Board of Examiners is one of the most progressive boards in the United States.

National Board Examination.—The examination held by the National Board of Medical Examiners in Philadelphia, June 2 to 7, had fifty-two candidates, the largest number in the history of the board.

Bill Against Vivisection Proposed.—In a bill recently introduced in the Senate, Senator Myers, of Montana, would prohibit experiments on living dogs in the District of Columbia, territories and insular possessions.

Appropriation for Study of Influenza.—The Committee on Scientific Research of the American Medical Association has made an appropriation for the preparation of a critical summary of the epidemiology and bacteriology of the influenza pandemic. The work has been placed in charge of Prof. Edwin O. Jordan, of the University of Chicago. Reprints of articles and statistical records may be forwarded to Prof. Jordan as soon as published.

Increase in Drug Addicts.—According to its final report, issued June 13, the Treasury Department states, through its special investigating committee, that the nation-wide use of narcotic drugs for other than legitimate medical purposes has been steadily increasing in the United States during the last four years, despite vigorous efforts in the enforcement of the Federal law. The number of drug addicts in the United States is estimated to be in excess

of 1,000,000, and the imports of opium products and coca leaves into the United States have increased twice as rapidly as the growth of population.

PASTEUR INSTITUTE AT ATHENS FOUNDED.—The Greek Government has received a donation from M. Zacharoff for the foundation of a Pasteur Institute at Athens. The new institute will be founded on the same lines as that in Paris.

PERSONALS.—Dr. Isadore Dyer has been commissioned Colonel in the Medical Section, Officers' Reserve Corps, U. S. Army.

Dr. C. Jeff. Miller has returned from a five weeks' vacation spent in Atlantic City and other points in the North.

Dr. Charles Chassaignac and family are spending the month of August in Manitou, Colorado.

The Adams-Gradwohl Biological Laboratories have been established in New Orleans, with headquarters in the Maison-Blanche Building Annex. Dr. Geo. B. Adams is associated with Dr. B. H. Gradwohl, of St. Louis, as head of the New Orleans branch.

Dr. Adolph Henriques and associates, Drs. L. J. Menville and W. J. Devlin, announce that they are prepared to treat all cases in which the use of radium is indicated.

Among the Louisiana men who have returned since our last list from service in this country or abroad are: Drs. J. T. O'Ferrall, J. C. Menendez, A. E. Naef, L. J. Robin, J. W. Rosenthal, I. N. Tucker, G. C. Remley, New Orleans; G. W. Wright, Monroe; T. J. McHugh, Baton Rouge; H. L. Crow, Elm Grove; E. B. Middleton, Heflin.

REMOVALS.—Dr. H. W. Mannings, from Eureka to Emporia, Kansas.

Dr. H. Daspit, from 1225 Maison Blanche Building to 415 Medical Building.

Dr. S. D. Wall, from Baton Rouge, La., to Grayburg, Texas.

MARRIED.—On June 24, 1919, Dr. M. M. Mouton to Miss Alice Louise Campbell, both of Lafayette, La.

BOOK REVIEWS AND NOTICES

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* JOURNAL *to review as many of the works accepted as possible, the editors will be guided by the space available and the merit of respective publications. The acceptance of a book implies no obligation to review.*

The Disabled Soldier, by Douglad C. McMurtrie. The Macmillan Company, New York.

The author has splendidly set forth the possibilities for the crippled soldier. First, there is a review of the history of practices regarding the care of the wounded soldier in earlier times. The origin of comfortable provision for such soldiers is given, and the story is brought from its beginnings up to the present time. To all who are interested in the future of our soldiers who have suffered loss of limbs or sight, the book is full of sympathetic suggestions, and wherever reconstruction is undertaken the broad encouragement of the author will bring help. DYER.

The Practical Medicine Series, 1918. Under the general editorial charge of Charles L. Mix, A. M., M. D. **Volume 1, General Medicine,** edited by Frank Billings, M. S., M. D., assisted by Burrell O. Raulsten, A. B., M. D. The Year Book Publishers, Chicago.

This is an excellent mirror of the progress made during the past year in the field of general medicine. The editors have carefully sifted, from a mass of good material, that which they deemed to be best, and presented it in abstract form, together with editorial comment. In reviewing a work of this type it would be difficult to select any particular group of articles for special discussion. As a work of reference, the Practical Medicine Series is of inestimable value.

GEO. S. BROWN.

The Diseases of Infancy and Childhood, by Henry Koplik, M. D. Fourth edition, revised and enlarged. Lea & Febiger, Philadelphia and New York.

In reviewing so popular and well-known a work as that of Dr. Koplik, little more is necessary than to record the changes that have been made incident to the advances in the various fields of pediatrics. In this edition many subjects which were more or less obscure when the third edition was published have received careful attention. This is noticeable particularly in the chapter on Acidosis in Infancy. While the last word concerning the various problems of infant feeding has not been spoken, the section devoted to this important subject contains much that is new and helpful in the daily work of the practitioner. This applies as well to the chapters upon Diphtheria, Poliomyelitis, Meningitis and Tuberculosis. In revising the chapters upon Circulatory Diseases the author has placed emphasis upon the more recent methods of diagnosis and treatment.

One of the strongest forces of Dr. Koplik's work is the liberal space allotted to the symptoms and treatment of the various diseases, and it is refreshing to note that he handles the subject in a concrete, rather than an abstract, way.

Valuable statistics, taken directly from the author's hospital experience have been introduced throughout the work. The book is illustrated with 239 engravings and twenty-five plates in color, many of which are new.

GEO. S. B.

Practical Physiological Chemistry, by Philip B. Hawk, M. S., Ph. D. Sixth edition. P. Blakiston's Son & Co., Philadelphia.

This latest edition of Hawk's Physiological Chemistry is very timely, and is, from many viewpoints, excellent. The several foodstuffs and their derivatives are discussed thoroughly in the first part of this work, followed by a full and up-to-date review of the digestions.

The chapter on Acidosis is of marked value to the student of medicine, and the newer methods of Van Slyke and Cullen and others, for the accurate estimation of this condition, are given in detail.

In the section dealing with Blood Analysis the reader will find exact and full working data for the newer methods of carrying out blood chemistry.

As in the previous editions, the section discussing the Chemistry of the Urine is thoroughly and clearly stated. The closing chapter briefly reviews Metabolism, and includes a statement of the recent work of Osborne and Mendel dealing with the influence of accessory food substances—i. e., Fat Soluble A and Water Soluble B.

The pages discussing the influence of Physical Exercise upon Blood Sugar and the timely relations of Protein Metabolism are of much value and strengthen this splendid work.

F. P. CHILLINGWORTH.

Le Français, by P. Dessagnes. Masson & Co., Paris, 1919.

This is the first volume of an elementary course to teach the French language to foreigners, but even in that volume it is possible to introduce a subject of greater interest—that of the French nation itself, its history and its literature. As the publishers put it so well: "That American youths should learn what France really is, and that the new French generations should try to get acquainted with America—is this not, for the well-being of the world, 'a consummation devoutly to be wished?'"

C. C.

Practical Medicine Series. Volume III. **The Eye, Ear, Nose and Throat.** Edited by Casey Wood, Albert H. Andrews and George E. Shambaugh. Series 1918. The Year Book Publishers, Chicago.

The editor of the Eye Department, Dr. Casey Wood, reminds us that the world-war has affected even even ophthalmic literature, besides killing off some of our best observers and experimentators. However, much valuable material has been added to our stock of knowledge, and the substance of this matter has been ably presented in the present volume of the Year Book.

It is gratifying to learn that Dr. Casey Woods' removal to California will not cause a cessation of his editorship of this valuable series of books.

The Ear Department and the Nose and Throat Department are edited by Dr. Andrews and Dr. Shambaugh with their accustomed ability. The present volume takes it normal position alongside of its predecessors as a valuable summary of the progress realized in the subject discussed.

McSHANE.

Concerning Some Headaches and Eye Disorders of Nasal Origin, by Greenfield Sluder, M. D. With 115 illustrations. C. V. Mosby Company, St. Louis.

In this striking work Sluder has given to the profession the fruit of many years of work in one of the most distressing fields of pathology. The subject of headache, migraine and trigeminal neuralgia has occupied the attention of mankind ever since headaches obtruded themselves on human notice. The multiplicity and wide distribution of the origin of this distressing symptom caused the profession to grope for centuries after the causes and cure of this ailment, and the search is not yet ended. Many contributions have been made to the elucidation of the subject, and Sluder's is the latest and perhaps one of the most notable. The connection of nasal disease and headaches has long been known, but, even so, much remained to be explained, and Sluder has rendered a notable service in gathering valuable material from all sides, and offering it in a clear, concise and well-digested form. Not the least valuable of this material is culled from his own experience.

The sufferer from long-standing migraine or tic-douloureux is an object of pity. Unfortunately, for a long time these cases baffled medical science, but now a bright ray of hope is held out by Sluder, for he has presented the subject in a new and scientific light, and has considerably narrowed down the list of "incurable cases." He brings out forcibly the importance of so-called "vacuum headaches." The part played by Meckel's ganglion in the etiology of these pains is clearly traced, and the means of combating them are fully described. He also stresses the importance of hyperplastic sphenoiditis and post-ethmoido-sphenoiditis in their relations to ocular symptoms and neuralgic disorders. How distressing this neuralgia can become is well shown by a remark of a patient of the writer's a few weeks ago. The patient was a powerful machinist, with acute suppuration of the antrum; the pain was so intense that he volunteered the information that he now understood why some men commit suicide. The agonizing pain of these sufferers should stir every one of us to do his best to give relief. Those who have tried and failed in their efforts can get fresh inspiration by carefully studying Sluder's valuable works. The full descriptions of the operative technic are adequately supported by numerous excellent illustrations, many of which are original with the author. McSHANE.

PUBLICATIONS RECEIVED

W. B. SAUNDERS COMPANY, Philadelphia and London, 1919.

The Medical Clinics of North America. March, 1919.

J. B. LIPPINCOTT COMPANY, Philadelphia and London, 1919.

The Essentials of Surgery, by Archibald Leete McDonald, M. D.

F. A. DAVIS COMPANY, Philadelphia and London, 1919.

A Manual of Exercises for the Correction of Speech Disorders, by May Kirk Scripture, B. A., and Eugene Jackson, B. A.

Gyno-Plastic Technology, by Arnold Sturmdorf, M. D.

C. V. **MOSBY COMPANY,** St. Louis, 1919.

Pediatrics, by Malford W. Thewlis, M. D. With an introduction by A. Jacobi, M. D., LL. D., and I. L. Nascher, M. D.

Symptoms of Visceral Disease, by Francis Marion Pottenger, A. M., M. D., LL. D., F. A. C. P.

GOVERNMENT PRINTING OFFICE, Washington, D. C., 1919.

Public Health Reports. Vol. 34, Nos. 21, 22, 23, 24 and 25.

MISCELLANEOUS:

Squibb's Materia Medica for the Physician and the Surgeon. (E. R. Squibb & Sons, 80 Beekman street, New York.)

Japanese Medical Literature. (Reprinted from the **China Medical Journal,** Presbyterian Mission Press, Shanghai, China.)

Freedom's Call. .A Patriotic Address, by Curran Pope, M. D.

John Coakley Lettsom and the Foundation of the Medical Society. (Presidential address delivered before the Medical Society of London, by Sir St. Clair Thomson, M. D., F. R. C. P., F. R. C. S.)

The Johns Hopkins Hospital Reports. Vol. XVIII. (The Johns Hopkins Press, Baltimore, 1919.)

Report of the Health Department of the Panama Canal. July, August, September, 1918. (The Panama Canal Press, Mount Hope, C. Z., 1919.)

The Chemical Foundation, Incorporated. (Address by A. Mitchell Palmer and Francis P. Garvin, New York, 1919.)

REPRINTS.

Some of the Salient Duties of a Nurse, by S. E. Earp, M. D.

A Brief Report on Pandemic Influenza in Korea, With Special Reference to Its Etiology, by Frank W. Schofield, D. V. Sc., and H. C. Cynn, M. D.

MORTUARY REPORT OF NEW ORLEANS.

Computed from the Monthly Report of the Board of Health of the City of New Orleans, for June, 1919.

CAUSE.	White.	Colored.	Total.
Typhoid Fever	6	3	9
Intermittent Fever (Malarial Cachexia)	1	------	1
Smallpox	------	------	------
Measles	------	------	------
Scarlet Fever	------	------	------
Whooping Cough	------	1	1
Diphtheria and Croup	------	------	------
Influenza	3	3	6
Cholera Nostras	------	------	------
Pyemia and Septicemia	------	1	1
Tuberculosis	37	38	75
Cancer	25	12	37
Rheumatism and Gout	1	3	4
Diabetes	6	------	6
Alcoholism	1	------	1
Encephalitis and Meningitis	1	------	1
Locomotor Ataxia	------	------	------
Congestion, Hemorrhage and Softening of Brain	12	15	27
Paralysis	2	1	3
Convulsions of Infancy	------	------	------
Other Diseases of Infancy	11	6	17
Tetanus	------	2	2
Other Nervous Diseases	2	1	3
Heart Diseases	70	27	97
Bronchitis	1	------	1
Pneumonia and Broncho-Pneumonia	12	16	28
Other Respiratory Diseases	3	2	5
Ulcer of Stomach	1	------	1
Other Diseases of the Stomach	------	------	------
Diarrhea, Dysentery and Enteritis	15	17	32
Hernia, Intestinal Obstruction	5	1	6
Cirrhosis of Liver	2	2	4
Other Diseases of the Liver	4	2	6
Simple Peritonitis	------	------	------
Appendicitis	9	2	11
Bright's Disease	26	12	38
Other Genito-Urinary Diseases	11	5	16
Puerperal Diseases	7	4	11
Senile Debility	3	1	4
Suicide	3	------	3
Injuries	24	17	41
All Other Causes	12	24	36
TOTAL	316	218	534

Still-born Children—White, 16; colored, 17; total, 33.

Population of City (estimated)—White, 283,000; colored, 106,000; total, 389,000.

Death Rate per 1,000 per Anum for Month—White, 13.40; colored, 24.68; total, 16.47. Non-residents excluded, 12.45.

METEOROLOGIC SUMMARY (U. S. Weather Bureau).

Mean atmospheric pressure..... 29.99
Mean temperature..... 80.
Total precipitation..... 4.50 inches
Prevailing direction of wind, southeast.